Wh Is to Blame When Babies Are Mixed Up?
For ula Room Experiment in Terminal Sterilization
Me ical Social Service for the Private Patient

August
VOLUME 69
NUMBER 2
1947

The Modern Hospital

ANTON VAN LEEUWENHOEK (1632-1723). Invented the microscope. With an unexplored natural world before him, all of his observations of bacteria, protozoa, hydra and many other organisms were discoveries of startling importance.

FORWARD STEPS IN SCIENCE

As van Leeuwenhoek's invention of the microscope led to development of the high powered instruments now indispensible in present day medical practice, so in surgery, Sklar's discovery that the proper alloy of *American made* stainless steel is the perfect metal for surgical instruments, led to the manufacture of the finest instruments Surgery has ever known.

Almost unrecognized, except by experienced metallurgists, the technical advances made in the United States by steel manufacturers, during the past decade, won for America unquestioned leadership in steel making. Today American steel mills are making high grade stainless steels that never have been equaled anywhere before.

It is a special alloy of this world's finest stainless steel—*American made* stainless steel—that gives to Sklar instruments their incomparable quality—that has made the name Sklar on a stainless steel surgical instrument a guarantee of complete dependability under all conditions.

The J. SKLAR MFG. COMPANY today makes the greatest variety of stainless steel surgical instruments ever produced by a single manufacturer.

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LONG ISLAND CITY, N.Y.

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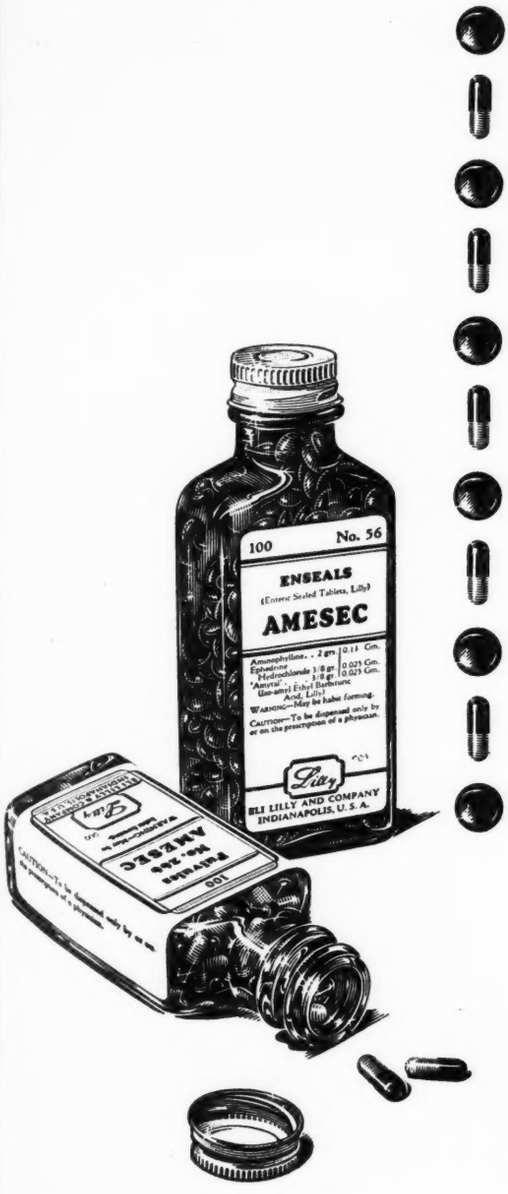
continuous symptomatic relief in allergic disorders



● Relief from allergic symptoms usually follows within twenty to thirty minutes after the oral administration of Pulvules Amesec and persists for several hours. Nocturnal attacks may be avoided or mitigated by taking advantage of the timed-disintegration feature of 'Enseals' (Enteric-Sealed Tablets, Lilly) Amesec. One pulvule and one of the 'Enseals' Amesec are prescribed by the physician to be taken at bedtime. The pulvule disintegrates promptly and controls symptoms for the ensuing three or four hours. 'Enseals' are timed to disintegrate in from four to seven hours. Thus, the medication is released at approximately the time at which the therapeutic effect of the pulvule is exhausted.

PULVULES AMESEC
. . . for prompt relief of asthma, hay fever, migraine, allergic rhinitis, hypotension, coryza, dysmenorrhea.

ENSEALS AMESEC
. . . for delayed action, to avert nocturnal symptoms.

Formula

Pulvules and 'Enseals' Amesec contain:

Aminophylline	2 grs.
Ephedrine Hydrochloride	3/8 gr.
'Amytal' (Iso-amyl Ethyl Barbituric Acid, Lilly)	3/8 gr.

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This Month

WE INTRODUCE....

If anybody can make sense out of the contretemps which results when newborn babies get switched, or seem to get switched, in the hospital nursery, **Emanuel Hayt** is the man. Foremost authority on the law as it relates to hospitals, Mr. Hayt has built a career—or, more accurately, two careers, since his law practice and literary tasks are shared by his partner, Mrs. Hayt—out of his special knowledge of such intricate subjects as the precise legal relationship of intern and hospital, appointment and relationships with the medical staff, responsibility for medical results, the admissibility in court of various kinds of hospital records and (see page 43) who gets which baby.

In addition to helping Mrs. Hayt, and being helped by her, with (her) (his) law practice and (his) (her) writing, Mr. Hayt lectures to students in hospital administration in the school of public health at Columbia University and at the University of Minnesota, and speaks on law at hospital conventions and on hospitals at law conventions. He and Mrs. Hayt have just published their third textbook, "Law of Hospital, Physician and Patient."

Robert H. Lowe, M.D., is assistant director at the Rochester General Hospital, Rochester, N. Y. The project described in his article starting on page 48 was carried out last year, when he was administrative assistant to **Dr. Basil C. MacLean** at the Strong Memorial Hospital, Rochester. Dr. Lowe is a graduate of the University of Vermont college of medicine.

James A. Hughes entered the hospital field by a route which is probably unique—he came in through a grocery store. As a young high school graduate, Mr. Hughes was weathering out the depression as a grocery clerk in Orono, Me. One of the store's regular customers was the late Hartley Ward, then chief engineer of the Eastern Maine General Hospital at Bangor. After they had become close friends, Mr. Hughes responded to Mr. Ward's persistent urging and forsook the apron for overalls—that is, he went to work as a fireman in the hospital boiler room.

"It wasn't an easy task," he says now of that first hospital job, "but the knowledge I gained in the boiler room has been of great assistance to me." Since that time, Mr. Hughes has served turns as night watchman, maintenance mechanic, assistant engineer and, finally, chief engineer, the position he holds today. He is a director and past president of the Bangor Junior Chamber of Commerce and a director of the State of Maine Junior Chamber as well, and a member and past president of the Bangor branch of the National Association of Power Engineers.

Florence Taub became interested in social work when, as a high school student, she was the president of a club organized to entertain chronically ill patients in a local hospital. She recognized then how much it meant to these sick people to be individualized and to have interest shown in them.

Miss Taub persisted in her interest in social work after she was graduated from New York University. For two years she attended graduate schools. The first year was spent at the Pennsylvania School of Social Work and the second year at the New York School of Social Work of Columbia University. She received the degree of Master of Social Science from the latter school.

Miss Taub's primary interest has always been medical social work; she spent five and a half years as a social worker at the Jewish Hospital of Brooklyn where she started as a case worker and was promoted to an associate case supervisor. It was at this hospital that she first received the idea to write the article which appears on page 62.

Norman D. Bailey, personnel director at Michael Reese Hospital in Chicago, is a relative newcomer to the hospital field, having been connected with Michael Reese since the fall of 1945. His earlier background in public school administration in New England and college teaching preceded the war period, which he spent in industrial personnel administration in one of Chicago's food plants. He still combines some teaching in the field of personnel administration, at Chicago's Roosevelt College, with his work at Michael Reese Hospital. Mr. Bailey believes firmly that hospitals must be as progressive as industrial organizations in their relations with and provisions for employes. A well balanced personnel department is a major step in such a program. At Michael Reese Hospital a G.I. on-the-job training program in personnel administration has been set up which is functioning effectively.

Mr. Bailey holds claim to being one of Chicago's champion long-distance daily commuters, since he covers the 52 miles between Plano, Ill., where he lives, and Chicago daily, using two trains, two street cars and an hour and forty minutes each way in his daily trip. The two Bailey youngsters, Al and Dan, with Mrs. Bailey, who teaches in the Plano High School, make up the family.

An interest in boats, the outgrowth of earlier years in New England coastal towns, and a working interest in vegetable gardening are Mr. Bailey's hobbies. The first of these is limited in an inland village like Plano, but the second finds plenty of outlet during the spring and summer months.

Ralph M. Hueston was recently named superintendent of Wesley Memorial Hospital, Chicago. Prior to his appointment there, he served for twelve years as head of the Hurley Hospital, Flint, Mich., and, earlier, as administrator of the Silver Cross Hospital, Joliet, Ill., and the Cottage Hospital, Galesburg, Ill.

Doris Ann Boyle, author of the article, "Let's Plan Menus," on page 102, is dietitian on the staff of the Veterans Administration. Her present assignment is at V. A. Branch Office No. 6, at Columbus, Ohio.

THE ROVING REPORTER

Guides to Sanatorium Life

Sanatorium patients have a long pull ahead of them. They need psychological preparation for their hospitalization; they must learn sanitary precautions; they must get oriented to their disease condition as well as to the sanatorium.

St. John's Sanitarium, Springfield, Ill., has a comprehensive guidebook for patients, which takes them from admission to discharge, physically, mentally and spiritually. It is called "To Greet and Guide Our Patients."

A companion volume is an employes' guide called "St. John's and You." It, too, must be more comprehensive than a general hospital's employes' manual to build safety consciousness, patients' morale and personal satisfaction in the job.

St. John's San Panion is a third publication worth mention. It is a monthly periodical with the patients as contributors.

Another monthly publication is *St. John's Sunbeams* which serves the youngsters in St. John's Crippled Children's School and Hospital.

Nice pieces of work, all of these. The Hospital Sisters of St. Francis have grasped publishing as well as the spiritual life and the sanatorium business.

Not Too Hard on Budget

An inexpensive but effective job is "Information for Patients and Visitors" recently issued by Pottstown Hospital, Pottstown, Pa., A. C. Seawell, administrator.

A sheet of coated paper, 9½ by 15 inches, printed in blue ink on both sides is folded horizontally and then vertically to form an eight page booklet. The horizontal fold is slightly off center making the two inside pages short so as to reveal a display line, "Important Information Inside." The reader, having digested the copy on pages 2 and 3, lifts them to find four more pages of information. No binding, stapling or cover stock is required, yet it is a complete job.

Each set of rules or suggestions is set off with tiny drawings which have the familiar flavor of a national hospital publication (be sure to ask permission for borrowing illustrations if you plan to imitate the Pottstown folder for the magazines are protected by copyright).

This is not the professional looking booklet that some advertising or publicity agency could turn out but it serves the purpose admirably, as to both copy and format, and should be well within the budget of a fairly small hospital.

Never Too Late to Explain

What does a hospital need of a station wagon? Jamaica Hospital, Jamaica, Long Island, used its station wagon on the streets for six years before it learned that the citizens generally were curious about it.

Having discovered that people were interested, Supt. Francis C. Leupold lost no time in tracing some of the station wagon's journeys. His medium was the Jamaica Hospital *News* of which he is the editor.

What an important part of the social service program of the hospital the station wagon is, Mr. Leupold let his public know. He told how it carries cardiac patients, who are not allowed to travel on public conveyances or do not have access to such transportation, to and

from the hospital clinic; how it picks up orthopedic patients who would require help getting in and out of public carriers and brings them to the hospital for treatment.

"This is one of the hospital's many hundred services to the indigent of the community, one that you help to maintain if you are a contributor," Mr. Leupold pointed out. "If you are not a contributor (the cost is $5 or more a year), you will find it a great personal satisfaction to know that you are part of the medical service we are rendering the indigent in this vicinity."

Now the station wagon can be talked about constructively when it is seen upon the local streets and several new contributors are helping to maintain the hospital's service to the community.

Choice Bait

When a director of nursing service gets an employment prospect these days, she doesn't want that prospect to wiggle off the hook.

At New York Hospital, that big beautiful hunk of architecture on East Sixty-Eighth Street, New York City, Virginia M. Dunbar, director of nursing service, isn't taking any chances. Rather than send a typed letter or some mimeographed material that lacks sales appeal, the hospital has recently prepared a snappy brochure to mail or hand out to all those who make inquiries.

This folder has no less than 11 illustrations, some business-like, some cozy, and the copy, while concise, answers all the questions the graduate would probably ask: residence facilities and charges for those who wish to "live in"; nursing services available; requirements for appointment; health benefits; opportunities for advancement; inservice program; opportunities for study; scholarships; hours; salaries; vacations and holidays.

The salaries, you may want to know, are from $2400 to $2640 for general staff nurses; $2460 to $2700 for assistant head nurses; $2640 to $2940 for head nurses; increases are on merit. For evening and night duty there is an additional $10 a month.

Four week vacations are offered after eleven months of continuous service contingent upon at least one month of work after the vacation. Thereafter, four week vacations are given annually. Four free hours are granted for each of nine official hospital holidays.

Old Families Serve

In a four story special hospital at Western Reserve University is a group of satisfied patients for which suitable accommodations have been designed. Besides treatment for disease conditions, these patients get preventive and health attention. Diets vary widely and are scientifically calculated.

Their comfortable quarters, nourishing food and fine medical and surgical attention do not cost them as much as a Roosevelt dime. For these patients are experimental subjects and form a central pool for investigative work done in various departments of the school of medicine.

When new patients are admitted they are segregated and inspected for disease, injury and parasites. All injuries and infections are corrected and then they are transferred to their regular quarters.

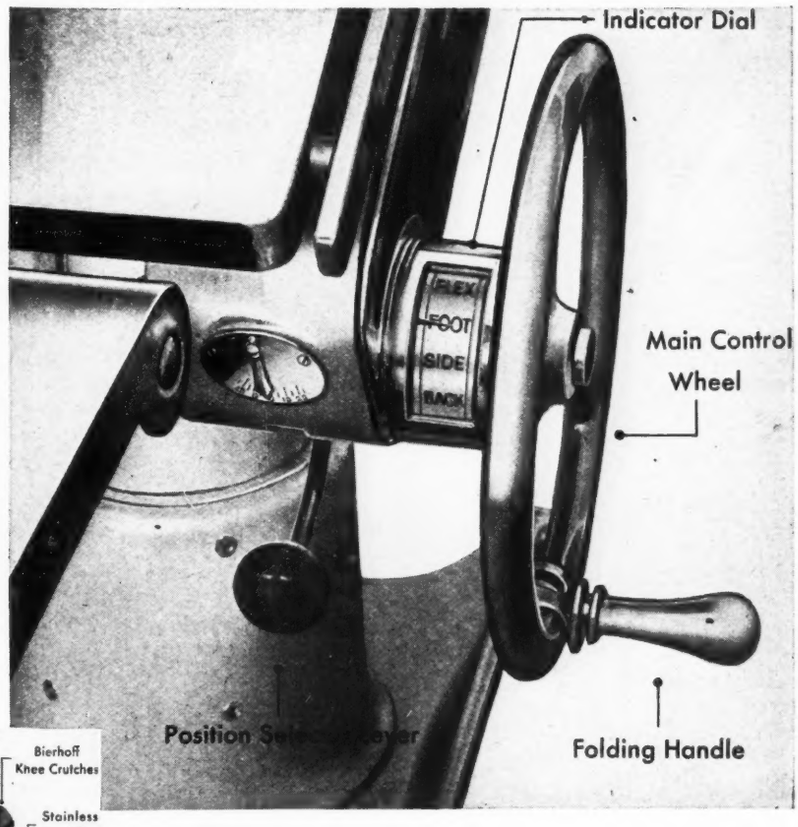
Since they contribute so much to scientific knowledge, it might be well to name a few of the patients for their families are well known to science and to art: Mlle. Chât, Dame Dog, Mr. R. Monkey, Peter Rabbit, Chicken Little, Gen. G. P. Guinea Pig and Brother Rat.

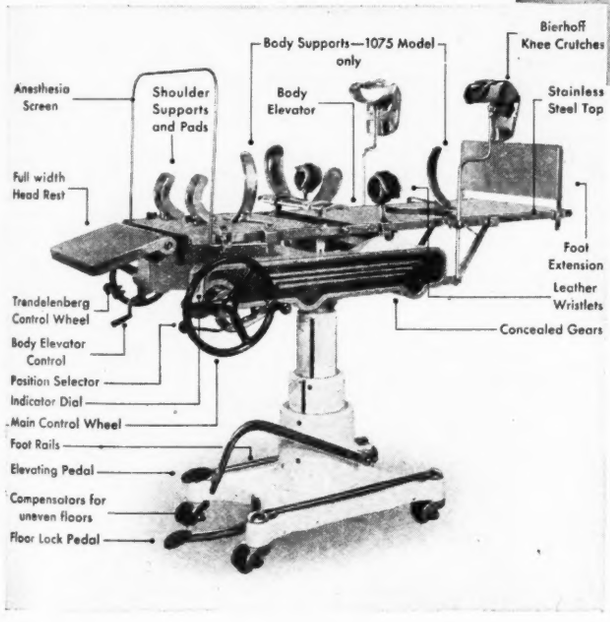
As Dr. Richard D. Larcey, new chief of the hospital, declares: "The work done on our patients has contributed greatly to the alleviation and prevention of illness among vast numbers of pets as well as human beings. Were it not for animal experimentation it would not be possible to cure many of the diseases that occur among animals." Go tell that on the mountain that antivivisectionists make out of a molehill.

When seconds and precision count . . .

The AMERICAN-1075 OPERATING TABLE

offers exclusive mechanical innovations that contribute towards greater speed, precision and convenience in surgical posturing.





THIS superior Table features an INDICATOR DIAL and POSITION SELECTOR LEVER which permit the anesthetist—while remaining seated—to properly select the precise table position to correspond with the anatomical posture changes called for by the surgeon . . . or posture changes called for by the anesthetist for physiologic reasons.

These exclusive innovations eliminate delay and confusion in establishing postures required both before and *during* the operation . . . and avoid any interference with the surgical team. Where speed and precision are contributive to the more successful attainment of the surgical objective, these featured advantages are of obvious clinical importance.

MEETS EVERY SURGICAL NEED

Offers unprecedented accessibility and convenience for the surgeon in all suprapubic approaches, abdominal, gall bladder, kidney, thoracic, thyroidectomy, gynecologic, neurosurgical, cystoscopic and the many other postures of the surgical category.

Offers a full 15" height range at levels from 31 to 46 inches from floor to top of table, thus permitting a standing or seated approach for surgeons of varying heights.

WRITE TODAY for descriptive literature

AMERICAN STERILIZER COMPANY

Erie, Pennsylvania

DESIGNERS AND MANUFACTURERS OF SURGICAL STERILIZERS, TABLES AND LIGHTS

READER OPINION

For The Defense

Sirs:

Re: The MODERN HOSPITAL *v.* The American College of Radiology (July 1947, p. 41).

Comes now the defendant in the above named case, hereafter referred to as "Lay That Pistol Down!" and avers that the complaint therein is bad in substance (though well pleaded and of good form and style).

The said defendant avers that the complaint and indictment filed by said plaintiff is replete with allegations unsupported by the evidence and innuendoes unjustified by the record.

Specifically the defendant objects to the willful misrepresentation perpetrated by said plaintiff in excluding from the record the following portions of the original evidence:

"No action has been taken on any question until after that question was viewed in relation to another: 'What is best for the patient and for the public welfare?' By remaining constant to the purpose of placing the welfare of the public before the private or group interests of radiologists, the College has achieved success."

Further the affiant saith not.

Mac F. Cahal
Executive Secretary
American College of Radiology
Chicago

Oversight

Sirs:

In reading the publicity material for student nurses, I notice that the emphasis is on what the nurse gets. Little or nothing is said about her opportunity to give. If she enters the nursing field only to get, isn't it taking a great deal for granted to expect her to have all the unselfish virtues after graduation? Sight is being lost (am I right?) of the basic thing in nursing—service. At any rate, I want my nurse really to care whether I live or die.

Ada Belle McCleery
Geneva, Ill.

Equipment For China

Sirs:

Now that it has become easier for hospitals to purchase equipment and supplies, no doubt many readers of The MODERN HOSPITAL are replacing items which would be received with little short of reverence in parts of China that for years were virtually shut off from communication with the West.

Equipment, such as autoclaves, microscopes, thermometers, scalpels, forceps, surgical scissors, stethoscopes and pill machines, as well as drugs, sutures, biological stains and medical books and journals, are being sought for the International Peace Hospitals in a current gifts-in-kind campaign in response to an urgent appeal from Madame Sun Yatsen, chairman of the China Welfare Fund. These nine base hospitals with their 42 branches and a system of mobile units are the outgrowth of the work of the late Dr. Norman Bethune, the Canadian chest surgeon, and serve the population of large areas in North China.

The International Peace Hospitals are one of the projects assisted by the China Aid Council, a cooperating organization of United Service to China with its nonpartisan program of help to all of China.

Gifts in kind can be shipped, or inquiries can be made, to the China Aid Council, 1790 Broadway, New York 19, N. Y.

Claude E. Heaton, M.D.
New York City

How the Strike Ended

Sirs:

On page 154 of the May issue of The MODERN HOSPITAL the article "Hospital Mechanics Quit in Union Dispute" leaves the reader in doubt as to the outcome.

You may have received information for a follow-up on this. If not, here is the story.

The mass resignation which took place Monday morning, April 21, ended to all intents and purposes on Tuesday noon, April 22, and by Wednesday noon all the men except one were back on their regular shifts. The one exception was paid off at his own request.

The only issue, that of union recognition, was settled by agreement of the men to return to work without it (although they are, of course, free to retain their union membership) and to work directly with the director of the hospital on matters of wages.

Public opinion, which in turn was expressed to many of the men by their families, was generally against union recognition, while crude tactics by the union professionals may also have influenced their decision.

In any event, the affair ended with no harsh words at any time between the management and the men, and regular meetings between the two are being held at the present time.

A. H. Marshall
Director of Public Relations
Grace-New Haven
Community Hospital
New Haven, Conn.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Those Visitors Again

Question: From the public relations as well as "welfare of the patient" points of view should visiting be more or less restricted than it is at present? Have we perhaps used the war as an excuse for our desire not to be bothered with visitors?—R.H.D., Pa.

ANSWER: While I think it is true that the war has been the "excuse" for limiting visiting, I am confident that reasonable limitations on visiting are appreciated by the patient, physician and nurse, although not always by the relative or friend. In our own experience we found it necessary to relax our wartime restrictions, which provided for only two visitors during any one visiting hour, to the more liberal policy of permitting two visitors at any one time during a visiting hour. This definitely has helped in our public relations although I am not so sure that the benefits have been transferred in equal measure to the patient.—WILLIAM J. DONNELLY.

Can We Raise Rates?

Question: Can hospitals keep on increasing rates to meet rising costs?—E.E.D., N. J.

ANSWER: Hospital trustees must raise rates to the general public, after examining their entire program carefully, if there is no other way out. On the other hand, we must not forget that hospital rates today are at the danger point from the standpoint of the ability of the public to pay, and hospitals must stop the vicious practice of overcharging the patients of private doctors (these are usually semiprivate and private room patients) in order to make up the deficit caused by unreasonably low payments from state, city and county governments for the care of indigents.

Fortunately, conditions in this respect are rapidly improving. The hospitals in some cities, after ten years of almost fruitless negotiations, have finally forced the counties into paying more reasonable rates. They still have a long way to go, however. Voluntary hospital boards of trustees must insist, through cooperative effort of all hospitals in a given area, that state and local units of government pay hospitals on the basis of the new governmental reimbursable cost formula.

Furthermore, hospitals must pay far more attention to ways and means of economizing on operating costs. As an example, there is no reason for having graduate registered nurses provide more than 30 per cent, or at the outside 40 per cent, of the total hours of nursing care per patient per day. Experience and careful tests have proved beyond doubt that practical nurses or nurse's aides trained on the job can take care of 60 per cent and, some authorities claim, from 75 to 80 per cent of the total nursing load.

Economies can be effected in the pharmacy through the establishment of a simplified standard formulary for the hospital. Money is still being thrown away in large quantities through inefficient combustion in the boiler room. Surgical procedures and setups in the operating room can be standardized, thus reducing personnel hours. Simplification and standardization programs on nursing procedures, equipment and supplies can be carried out throughout the hospital. In short, hospitals must do as industry did long ago—study their jobs, analyze their operations and go into a full scale operating economy program.—E. W. JONES.

School for Attendants

Question: (1) What requirements must a hospital meet to enable it to conduct an approved school for hospital attendants? (2) Is there anything in the requirements for approved schools of nursing which would prohibit a hospital now conducting a school of nursing from conducting an approved school for hospital attendants also?—F.C., Wis.

ANSWER: 1. Several states have set up their own standards for approved schools for hospital attendants. Hospitals, therefore, should acquaint themselves with these rules and regulations and meet the requirements before establishing a school for attendants. If no standards have been set up by the state, the American Hospital Association can furnish the required information.

2. There is no law or ruling as far as I know that would prohibit a hospital now conducting a school of nursing from also conducting an approved school for hospital attendants. It could be that some states have their own regulations in this regard and it would be wise to obtain this information before making definite plans for instituting a school for hospital attendants.—A. A. AITA.

Polio Treatment Centers

Question: Should the acute cases of anterior poliomyelitis be cared for locally or sent to presently established treatment centers?—H.M.C., Wis.

ANSWER: Whether or not polio cases should be cared for locally or in treatment centers depends on: (1) the type, stage and amount of involvement of the case; (2) the facilities at hand in the local community and the experience of the local physician; (3) the balance between the danger of transportation as against more rigorous treatment. The financial status of the patient is not to be considered but does have some bearing from a practical standpoint.—Roger W. DEBUSK, M.D.

Introducing 40 Hour Week

Question: How can the 40 hour work week for staff nurses be most satisfactorily introduced? Will the five day week meet the institutional needs? Could four full days plus two half days a week be substituted?—Sr. M.A., Wis.

ANSWER: Probably the most satisfactory method of introducing the 40 hour work week for staff nurses is to hold a conference of staff nurses with the director of nursing service and allow the staff nurses to submit plans for their work week keeping in mind the patients' care.

There are several methods suggested in recent issues of the *American Journal of Nursing* that are working out satisfactorily, probably because of the voice that the staff nurses had in making the plans.

The five day week does require additional workers and with the shortage of registered nurses it simply means employing more practical nurses, attendants and maids, as well as increasing their responsibility for the care of the patient. None of us considers this proper nursing care, but it is the best that is obtainable at the present.

The four full days plus two half days can be substituted if this arrangement is agreeable to the staff nurse, and it is being done. This is one method suggested by the staff nurses as a practical plan. Another method is to alternate the five day week with the four day plan, *i.e.* half of the staff works four full days and two afternoons one week and the other half works five full days.—JEWELL W. THRASHER.

LOOKING FORWARD

Night Shift

THE reluctance of many physician-specialists in urban areas to make house calls—especially at night and at the behest of patients they never heard of before—is perhaps understandable but certainly not in the best interests of the patient and the general popularity of the medical profession. Recognizing that not every night emergency is created by hysterical parents whose child needs a spanking more than a doctor, a number of county medical societies have formed panels of general practitioners who will respond to calls at any time, any place. This service is advertised to the public; the publicity features a telephone number which makes medical service available quickly at any hour.

Where such a system is in effect, families that have no regular doctor or whose doctor is out of town or away from home or office when called in an emergency are spared the chilling experience of reaching a doctor and being turned down. Inevitably, the whole medical profession gains from this service: People who get the brush-off from doctors, who are supposed to be noble and self sacrificing, often fail to keep their opinions secret.

Unfortunately, however, the number of medical societies offering the panel service on any organized basis is not large. Here is an opportunity, then, for the hospital to perform a valuable, needed function in the community, by organizing such an emergency panel among staff members. The hospital could then advertise—most newspapers and radio stations would be glad to cooperate in the program—that people who need a doctor and don't know how to get one can always call the hospital, which will relay the call to a doctor who will get up and go right away. The whole scheme stands or falls on the effectiveness of its publicity. The person who doesn't know that his hospital or local medical society will get him a doctor is no better off than the person whose hospital or medical society won't do it.

An official of one of the county medical societies now operating this kind of service warns: "All doctors on such a panel would have to agree to accept any call when it was given to them. To be practical the panel would have to include enough physicians so that any one of them may have the privilege of signing off for any brief period in the event that he would be out of town or away from duty for a stated length of time."

Practically every hospital could form a panel that would meet these requirements. If, as we keep telling one another, the hospital is going to be the focal point of community health care, this would seem to be one of its important functions. In a small way, it might even be part of the answer to the heckling from the left about maldistribution of medical services.

Footnotes on the Sands of Time[1]

SEEKING to show that early ambulation is not a new idea, an article in a recent state medical journal[2] quotes Dr. Squills in Vanity Fair, urging his colleague who was treating Miss Crawley to "Get her up! Get her out!" The quotation is dutifully scored with a footnote referring to "Thackeray, William Makepeace: Vanity Fair, Vol. 1, London, 1848."

Now most reasonable people can take scholarship or leave it alone, but this is pushing the scientific method to the rim of absurdity. Certainly documentation is needed wherever the professional reader will naturally wish to examine the evidence, look up additional works on a subject, trace a statement back to its source or simply know the authority for it. In most other cases footnotes are a nuisance, getting in the reader's way and distracting his attention from the main event; the writer will do better to "speak plain and to the purpose."[3]

Unfortunately, too many writers consciously or unconsciously figure that elaborate footnotes will give a commonplace or worthless paper the appearances of scholarly accomplishment: "O, what authority and show of truth can cunning sin cover itself withal!"[4] Sometimes, a writer who is habituated to the typographical hedgehopping that is mandatory in the medical journals may understandably become confused between the proper methods for handling literary allusions and scientific references. Undoubtedly, this is what has happened here.[5,6]

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[1] Apologies to Longfellow, Henry Wadsworth, *A Psalm of Life*.
[2] New York State Journal of Medicine **47**:1356 (June 15) 1947.
[3] Shakespeare, William, Much Ado About Nothing, Act II, Scene 3.
[4] Shakespeare, William, *Op. Cit.*, Act IV, Scene 1.
[5] See first paragraph above.
[6] See?

Kings County Corn

AN EDITORIAL plea for "less notes and more bedside care" in the Kings County Medical Society *Bulletin,* Kings County, New York, draws an ironic picture of a nurse who is endlessly occupied writing up charts which nobody will ever read, while her neglected patients wail for attention. Unquestionably, the author of the editorial amused himself and his readers, but it is doubtful that he accomplished much else except to reveal his own ignorance of what constitutes good hospital practice today.

As everybody knows, the nursing shortage has long since done away with this kind of charting for the chart's sake. Necessarily, paper work has been reduced to the minimum for hospital nurses everywhere and many hospitals now employ nursing unit secretaries to carry the greater part of the charting and clerical load and free the nurse for other duties.

Most revealing of all, however, is the Kings County author's contention that nobody reads charts anyway. After all, he says, the physician's "years of experience and just a few words and a quick glance at the face of his patient tell him more in sixty seconds than all the nurses' notes."

Baloney. The correlation between good hospital records and good medical care is universally recognized today, even in Kings County; when nurses include irrelevant information in their notes, the doctors under whose supervision they work are probably at fault. And even the occasional doctor who insists on his own omniscience and ignores nursing charts entirely has to have something to read and shake his head over, so he can look as wise as everybody knows he must be.

Wild Pitch

KICKING doctors and hospitals around in the public prints is rapidly becoming a definitive sport, like baseball, only it doesn't have such wholesome features as an umpire and white lines marking the boundary between fair and foul territory. Both these disciplines were plainly lacking, for example, in a recent sporting event called "Unnecessary Operations," by Albert Deutsch, which appeared in the *Woman's Home Companion* for July.

A good many surgical operations are unnecessary and are initiated primarily by the surgeon's interest in the patient's purse, according to Mr. Deutsch's little exercise, and a good many surgeons, however pure their motives, are unqualified to make diagnoses and to operate. It would be foolish to deny these assertions, which are simply equivalent to saying that one may find wicked and incompetent people in the medical profession, as well as among business men, labor leaders, debutantes and magazine writers.

Beyond this point, Mr. Deutsch begins to pitch wild. His references to unskilled or needless surgery as mayhem, manslaughter and even murder are obvious attempts to make the article a shocker, possibly excusable on the ground that nobody pays any attention today to unadorned statements of fact. It is hard to find any justification, however, for the disingenuous declaration that "about 40,000 practicing physicians perform surgical operations although fewer than 15,000 are certified specialists in surgery," a true statement which plainly, but untruthfully, implies that only certified specialists are qualified to do surgery.

Documenting his point of view abundantly with anecdotes about prematurely separated tonsils, appendices and uteri, Mr. Deutsch barely mentions the serious efforts of hospitals, medical organizations and publications to build safeguards against the evils he describes. Instead, he offers his own formula for the control of surgical practice, made up in about equal parts of sound programs which are already in effect in approved hospitals and weird suggestions which wouldn't work in a million years.

Among the juicier of the innovations proposed by Mr. Deutsch are state licensing of surgical specialists, full staff conferences to pass on every operation and salaries instead of private fees for all surgeons. *(Hut,* two, three, four, *hut . . . hut.)* Also on the Deutsch agenda are better staff organization and discipline, more consultations and sterner measures against fee splitting and other professional infractions—goals which thoughtful and progressive hospital administrators, trustees and staff officers are earnestly, if not always effectively, trying to achieve.

It may well be a fact, as Mr. Deutsch suggests, that public demand for these reforms will hasten their achievement everywhere. It may also be true that some public knowledge of the seamy side of surgery must precede the demand for change. But if these worth while objectives of public education can't be achieved without the kind of journalistic excess which runs so far ahead of the truth, then the time has come for some surgery, but major, in the magazine business.

Something To Do

SPEAKING at a public relations conference of Blue Cross executives a few days ago, Richard M. Jones, Blue Cross Commissioner, pointed out that with all the haranguing among plans and hospitals about rates and charges and payments, nobody has made a serious effort to find out precisely how much the public wants to pay or will pay for hospital care or hospital care insurance today.

This information wouldn't be easy to get, of course. But real "depth interviews" with an expertly chosen sample of the population should be productive of valuable knowledge. It might not be conclusive, but it would certainly help. At the very least, somebody would be doing something, instead of just sitting around talking.

It's a Case for King Solomon

When Babies Are Mixed Up

EMANUEL HAYT
Hayt and Hayt
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PARENTS Demand $200,000 for Boy-Girl Baby Switch." This was the featured headline on the front page of a New York City newspaper on May 14, 1947. A municipal hospital was accused by a couple of having substituted a boy for their eight day old girl, who, they declared, was still missing after two months. The parents charged that the switch was made after a birth certificate, signed by the physician officiating at the birth, had been issued for a female child. A second certificate was issued for a male child, signed by a nurse and mailed to the parents' home following the switch.

The mother was delivered by a cesarean section, but she was conscious throughout the operation. Following the baby's birth, she said, the physician showed it to her and announced it was a fine girl. She observed it was a female infant. Her husband was told over the telephone that his wife had borne a girl.

In the ward of the hospital, on the second day, the mother was given diapers to fold, and she used one on her baby girl which had the same light hair as her 18 months old son For the next six days the girl was brought to her for nursing. Eight days after the female child's birth, a nurse brought a dark haired boy, instead. The mother protested that it was not her baby, but her plea was ignored. Identifying colored beads had been worn about the girl's neck with the surname spelled out. The boy, she stated, bore a piece of adhesive tape with the same surname written on it in longhand.

On leaving the hospital, she received the dark haired boy. The husband went to the superintendent of nurses and the superintendent of the hospital to complain that he had been given the wrong baby. However, the hospital insisted the boy was his. They finally left the hospital with the boy.

It was alleged by the father that the second day after the boy was brought home, he received the second birth certificate. Later he was called to the hospital where he said the authorities tried to persuade him to surrender the first certificate. The first female certificate bore the official time stamp of the Bureau of Records; the second male certificate bore no time stamp and the date was written in longhand. It was signed by a registered nurse instead of a physician.

According to law, a birth certificate must be signed by the attending physician. If there is a corrected birth certificate it must be so marked and also be signed by the attending physician. A registered nurse is not permitted to sign a birth certificate in a city hospital. Registered nurses and midwives may sign certificates if a baby is born at home and no physician is in attendance.

The Commissioner of Hospitals admitted there had been a clerical error but insisted that the parents had the right baby. An attendant filling out the original application for a birth certificate from the department of health had written an F for female on the application instead of an M for male. The attending physician at birth, who signed the first certificate specifying a female child, now declared he knew it was a boy. The other staff members and nurses concerned in the operation agreed that the baby was a male. The supervisory nurse on duty when the child was born heard the mother say that she was happy it was a boy. All the records in the hospital indicated the child was a male.

Accompanying the newspaper story were photographs of the parents, the baby boy and the two certificates of birth.[1]

New York State has adopted the legal principle of "administrative negligence" which holds a hospital liable for acts of negligence not directly concerned with a patient's medical care.[2] If the jury at the trial accepts the parents' version of what happened and that the wrong infant was delivered to the parents, damages undoubtedly will be assessed against the City of New York.

BABY IDENTIFICATION

At this point it would be desirable to review the procedures followed by hospitals for the identification of newly born infants. Steps for the identification of the newborn should be taken before the child leaves the delivery room. Among the methods employed to avoid baby mixups are footprints, palm prints, adhesive sticker with name, name necklace and name tags. Some hospitals number the baby from the moment of birth.

Footprints should be carefully made so as not to be mere smudges or blots of ink. Baby mixups may lead to widespread and most unfavorable publicity. Courts and juries are sympathetic toward a distracted mother. The procedures of the hospital should be so foolproof as to

[1]New York World-Telegram.
[2]Dillon *v.* Rockaway Beach Hospital and Dispensary, 284 N.Y. 176, 30 N.E. 2d 458.

stand up under even the severe test of two deliveries at the same time, of the same sex, with parents of the same surname. Footprints made with the infants' toes all curled up and thumbprints that are smudges are valueless. Routine identification procedure is not enough; there should be a complete and prompt checkup of the evidence and records.[3]

It is advisable to adopt a uniform system in the marking of infants. The name tape method is an adequate primary system to use: a wide band carrying the name and sex in large bold letters identifies the baby. Footprints of the baby recorded with fingerprints of the mother are an added safety factor. Fairly good footprints can be obtained if the clean feet are placed on a highly polished inked surface and transferred to the birth certificate and the hospital record.

The identification, witnessed by at least one person, should be completed in the delivery room. At least three tape bands, one on each wrist and one on the ankle, should be used, all marked by the same bold type rubber stamp at the same time that the baby's chart, crib card and the back of the birth certificate are marked. Upon the discharge of the mother and infant, one of these tapes should be clipped, compared with the original in the mother's and baby's chart and sealed in an envelope with the signature of the mother across the sealed flap; this envelope is filed in the baby's chart and will serve as proof that the proper baby has been discharged with the mother.

One manufacturer has developed a blue bead necklace onto which are strung lettered white beads spelling the baby's surname; this can be quickly placed around the baby's neck before the umbilical cord is severed, thus removing the possibility of a mistaken identity.[4]

A young doctor has devised a plan to avoid mixups of newborn babies, to be used in conjunction with the usual precautions. He proposes a blood count immediately after the birth of a baby with the sample taken from the umbilical cord, which contains the infant's blood, not the mother's. This specimen is then attached to the mother's body.

There are six basic blood groups; also three so-called M-N types, 10 Rh-Hr types and two P factors. Every blood sample will come under one of each of the four classifications. By multiplying 6 times 3 times 10 times 2, 360 possible variations are obtainable. Although the system is not infallible it does go far in avoiding disputes or mistakes.[5]

BABY MIXUP CASES

1 About two years ago, in Los Angeles, the parents of an infant sued a hospital for $500,000, claiming the baby they thought was a boy at birth turned out to be a girl. Blurred footprints taken at birth did not aid in disposing of the matter. During the trial of the suit, the parents made a settlement for an unspecified amount of cash. The doctor who signed the birth certificate as attending physician had admitted in court that he may have been mistaken in writing the certificate.[6]

2 A case of an alleged mixup of two babies was tried in court for twenty-one days. The parents of both babies sued the hospital and the assistant superintendent. At the time of the incident the superintendent was attending a hospital convention. One of these cases was settled by the insurance company for $650; the parents of the other baby claimed separate damages for each parent.

At no time was there any question about the proper identity of the babies involved; the hospital had used the standard name tape; in the delivery room tapes were placed on the baby's wrists and on the ankle. These tags carried the name of the mother, sex of the baby, name of doctor and date and hour of birth. Footprints of the baby and thumbprints of the mother were recorded in the chart and birth certificate.

However, on the seventh or eighth day, the nurses placed the babies in the wrong cribs; led by the markings on the cribs instead of the name tapes, they took the babies to the wrong mothers for feeding. This was discovered on the tenth day and the error was corrected. The mothers, nevertheless, became suspicious that they had the wrong children. To satisfy the mothers, the name tapes and the system in vogue were reviewed with the parents. A police fingerprint expert confirmed the footprints and fingerprints.

The parents alleged, nevertheless, that they did not know whether they had the right baby; that three babies were involved instead of two, and that there was gross negligence by the hospital in the marking of the infants. Despite the conflicting evidence, the jury awarded the sum of $3500 as damages in favor of the mother and against the hospital. A non-suit was rendered against the assistant superintendent. Nothing was awarded to the father. The jurors also found that the mother received the right baby.[7]

3 Some states will not permit a recovery for mental pain and anguish, without proof of a bodily injury. In another case the hospital and the attending physician were sued on the ground that they first represented that the child was female and a few days later the parents were told that the child was a male.

Without asserting that the child was not theirs, the parents sought damages for $25,000, claiming that they suffered and would continue to suffer severe physical and mental anguish in feeling that the child given to them was not their own. There was no averment of expense or special damage.

The hospital moved to dismiss the complaint on the theory that there can be no recovery for purely mental anguish, agony, distress, pain or torment, in the absence of accompanying physical injury. The motion was granted.[8]

4 A mother and her week-old baby were brought to the hospital. Nine days later the mother died; her husband took her body to Canada for burial. He left the baby at the hospital with the assurance that for $1 a day the baby would receive the best of care. At about the time of the birth of this baby, the daughter of another man gave birth at the hospital to a child, the result of an incestuous relationship beween father and daughter. When the daughter was able to return home, she also left the baby for care at the hospital. This girl's father called for the baby and, through the negligence of a nurse, was given the first baby.

[3]Strube, Charles G., Jr.: "When Records Go to Court," Mod. Hosp. **54**:78 (June) 1940.

[4]Law of Hospital, Physician and Patient, Hayt and Hayt. New York: Hospital Textbook Co., 1947, p. 303.

[5]Suggest Blood Tests to Avoid Baby Mixups, Hosp. Mngement. **63**:120 (April) 1947.

[6]Babies' Records Altered or Lost, Lawyer Hints, New York World-Telegram, May 15, 1947, p. 2.

[7]Heermann, Ritz E.: "Suit Involving Mixup of Babies," Hosps. **8**:22 (August) 1940.

[8]Kaufman *v.* Israel Zion Hospital, 51 N.Y.S. 412.

When the father of the first baby called for it, the mistake was discovered. The father of the incestuous baby in the meantime had given away the wrong baby to some strangers passing in an automobile; it could never be found.

The court dismissed the complaint of the father of the first baby on the ground that there is no distinction, under the theory of the nonliability of charitable institutions, between cases involving damages to the person of a patient and his property, where such are caused by the wrongful act of an employe.

The record showed that the nurse responsible for the mistake was a registered graduate with a background of three years of hospital training prior to the occurence. In directing a verdict for the hospital, the court stated that there was no legal redress for the very grievous wrong done the father; that the great good generally accomplished by a hospital and the private contributions given for its support should not be impaired or even entirely deleted by responsibility for the occasional lapses of its employes.[9] In states in which the doctrine of administrative negligence exists, the hospital would be held liable.

[9]Greatex *v.* Evangelical Deaconess Hospital, 261 Mich. 327, 246 N.W. 137.

The Means Are at Hand

for building better public understanding

RAYMOND T. RICH

HOSPITALS that have built up good community relationships over a period of years can go with confidence to that community for help in time of financial stress. The occasional stories I hear of hospitals so deeply in the red that they are contemplating closing their doors cannot help but raise questions. If there is good management, if charges to the private patients are adequate and in line with cost, if the demand for hospital service is what it is reputed to be, what can cause these defeats? Something is wrong.

Is the hospital receiving proper compensation from the government agencies responsible for some of its patients? In many communities this is a real problem, for municipal authorities often do not pay anywhere near the full cost of the patient's care. Whatever the problem, the hospital that is public relations wise can go to the people with it and hope for concrete help.

If their records were based upon thorough cost accounting, hospitals would be in a far more favorable position to negotiate with agencies from which they receive payments for patient care. The day has gone when outmoded business methods can be used with impunity by the hospital just because it is a humanitarian institution. You must deal with a diversity of agencies today and with a public which will be asked to pay higher rates and also to contribute to fund raising campaigns. Never, therefore, has it been so necessary to have precise cost accounting data. You can win or lose your public with your financial operations, too.

Here, I should like to mention one of the hospital practices that has probably lost more friends than can be counted. That is the system of charging the patient a daily rate plus extra fees for various services. These seem to range from small nuisance charges for aspirin and the like to more sizable sums for x-ray examinations, operating room, laboratory and kindred services. Justified or not, the practice of tacking on these extra charges to the bill has probably generated a variety of unpleasant emotions in the patient—from annoyance to downright ill will. Can something be done about this? Also, by the way, about those nurses who have lost their professional standing to the extent of expecting and even exacting tips?

It is bad enough that the customary billing method makes it possible to confront patients with numerous unexpected charges for which he was unprepared. It also puts a price on every diagnostic procedure and many a curative service in such a way that the doctor probably hesitates before ordering it for the patient. Otherwise, how could it be that ward patients who do not pay these extra charges receive, on the whole, far more laboratory and x-ray service than do other patients?

It seems clear that hospitals are missing a great opportunity by not trying more widely, and improving, the so-called "inclusive rate" system which is based upon scheduled daily rates and includes practically all the extra services which the doctor may deem necessary. Apparently this has been tried by many hospitals and, granted that it presents some problems and has been abused by some doctors, it holds some worthwhile features that warrant further test and improvement.

For better or for worse Blue Cross will continue to be a strong influence in the hospital field. The public likes it. No one will dispute that it has been a workable means of lifting a

Condensed from a paper presented at the Tri-state Hospital Assembly, 1947.

heavy financial burden from its subscribers in time of illness requiring hospitalization. In turn, this has affected hospital finances. It is also not unlikely that Blue Cross channeled considerable good will to the hospitals during the trying war years when many other factors were creating ill will.

Therefore it seems to me, an impartial observer, that any rifts between Blue Cross and the hospitals should be watched carefully. An example is the controversy between those who wish to keep the service benefit feature in Blue Cross contracts and those who feel that it should be changed to payment of a cash allowance, with the hospital allowed to charge the patient the difference between the allowance and the final bill. Again, the controversy as to the basis of Blue Cross payments, with many persons heavily favoring a cost basis. Whatever the respective merits of each side, account should be taken of the chief factor in Blue Cross popularity: its uncomplicated service feature, served up to the subscriber with a minimum of complication. Hence, whatever the controversy, the best minds on each side must be addressed to the problem in order that justice be done to all concerned, to the hospital, Blue Cross and, most important of all, the subscriber whom both serve.

Problems Can Be Settled

Like every good thing, Blue Cross has brought problems to hospitals. I am aware, for instance, that there has been some complaint that Blue Cross insurance is responsible for utilizing hospital beds for minor illnesses at a time when hospital beds are scarce. But cannot we counter that Blue Cross is thus unintentionally teaching hospitals a preventive rôle in community health, a rôle in maintaining community health? That, in my judgment, is the greatest public relations opportunity for the hospitals of our country.

The hospitals of today are standing at the threshhold of a new era of service in their history and development. They are in the midst of great opportunities for fulfilling a new destiny, a new function, that of integral institutions existing not only for the healing of the sick and injured but also for the optimum health of the community as well. They could well become the rallying points for all the healing arts and all the forces for positive community health.

The 18th century concept of the hospital as a place of suffering and death has almost disappeared. I say "almost" because vestiges of it still remain to be a stumbling block. The public still thinks of most hospitals in terms of sickness and not in terms of positive health. The old vestigial fears still loom in the minds of the patient and his family when the necessity for hospitalization is announced by the doctor. That fear and hesitation at once reflect all they have ever known or heard or imagined about the less progressive hospitals and reveal what poor public relations such hospitals possess. And nobody *wants* to be the customer of that kind of hospital.

Those of you who envision a great future for hospitals as community institutions know that every trace of the 18th century feeling must be erased. Fortunately, present trends point to a new, more dynamic, more positive rôle for the hospital. The hospital of the future can be the center for distribution of all the health services of the community. Working hand in hand with its medical staff and leaders in the community, it can slowly change from its merely passive rôle and follow a positive program of searching out community needs. It can become a center for preventive health services as well as curative services. It can become the place to which people will want to go to keep well.

The hospital of the future will, of course, continue to serve as a well equipped workshop for its staff doctors. It may also provide, as many hospitals have already done, offices for its staff physicians so that all needed facilities will be available to the doctor in the course of everyday practice. Over and beyond that, it can respond with some wise action to the many voices now being heard in behalf of nonstaff physicians who are not in a position now to treat their own patients in a hospital. There is a growing feeling that hospitals should make some provision for opening their doors to all reputable physicians; that they should undertake to integrate the general practitioner into their programs.

Thus, hospital facilities would have even wider usefulness. Usefulness and good public relations go hand in hand. Therefore, let us look at further opportunities to be useful.

One, it seems to me, is the field of rehabilitation. Too often the patient is sent home with only the most immediate phase of healing accomplished. Physical and emotional rehabilitation after injury and illness is left to chance alone. Is there not much to be learned from the experience of military hospitals in this regard? The experiment at Bellevue Hospital, under the direction of Dr. Howard Rusk, seems worth watching at a time when most communities provide only in hit and miss fashion for this important work.

The acceptance of rehabilitation as a hospital function might well entail the extension of certain services into the home and it certainly would mean cooperative efforts with outside agencies. Both of these are desirable developments in themselves. And their public relations contribution would be immense.

Other Opportunities for Service

Another opportunity for greater usefulness would be in the field of better care for the tuberculous, the mentally ill, the chronically ill and those with communicable diseases. Today, most general hospitals are so poorly geared for the care of these categories of illness that they show almost indecent haste in discharging such cases to other institutions. While changes cannot come overnight, community hospitals will be missing a great opportunity for service, and hence for good public relations, if they do not at least institute active affiliation with special hospitals, with a full exchange of staff and facilities toward the goal of better care for the patient.

And what about usefulness to other community agencies? The hospital of the future may well recognize the public relations and service values that would ensue from cooperation with voluntary health agencies, such as tuberculosis and cancer societies. An example of the fruitful endeavor that can result is furnished by the tuberculosis case finding projects conducted by hospitals in recent years at the instigation of the antituberculosis agencies. And might the future see the public health officer and auxiliary personnel housed within the hospital? Certainly, the hospital seems to be a logical base of operations for public

health nursing personnel. Furthermore, duplication of x-ray and laboratory services could be eliminated and case finding activities would be facilitated.

Above anything else I should stress my belief that hospitals may be missing the greatest opportunity of all if they do not begin to broaden their horizons soon to include a policy of positive health service to the community. In the face of a need of better distribution of medical care, why not experiment with the group practice units, hospital-based, which would offer comprehensive medical care to large groups of patients on a prepayment basis?

It does not seem logical that experience in this field of endeavor has been acquired mostly under private and industrial auspices. It seems high time for doctors and the voluntary institutions in which they do their work to try out this opportunity for service—this public relations opportunity, if you will. The public is groping for something resembling comprehensive medical care; it is more than vaguely aware of the need. To whom will it turn?

Prepaid Service Envisioned

The kind of plan I have in mind is like the plan drawn up some time ago by the committee on future plans of a large metropolitan hospital. This envisioned a prepaid service, comprehensive and preventive in character, and furnished in the hospital by a group of physicians. Such a plan would make full use of diagnostic facilities now only partially used and, by the mass production principle, would reduce the unit cost. Thus, it could provide comprehensive medical care — preventive care, health maintenance—at a reasonable cost to a public ready and educated for this type of service. We cannot go on forever preaching preventive medicine without providing the means whereby the people may obtain it.

Some of you may well ask what cooperation you could expect from the medical profession in such planning. I am mindful that medical press editorials have appeared from time to time accusing the hospitals and Blue Cross of trying to control the practice of medicine. On the other hand, there are hospital people who have annoyed doctors by frankly advocating the overthrow of the present practice of medicine in favor of full time salaried staffs for hospitals. I believe that on the whole most doctors think of the hospital as their special workshop; that they and the hospital administrators understand each other.

Experimentation such as I have mentioned cannot even begin without the full understanding, willingness and cooperation of the medical staff. If there are real good will and understanding on both sides, much can be accomplished. If there are not full understanding and receptiveness on the part of either side, is there not perhaps a job of education that has to be done? After all, there is a need to be filled. The hospital alone cannot possibly fill that need; the physician alone cannot fill it. If planning is done together, if new projects are approached in the spirit of full partnership rather than the spirit of who is going to boss the show, I believe there will be most fruitful cooperation.

The picture of the hospital-health center of the future presents an interesting challenge. I am sure, however, that the hospital administrator does not see it as a rosy dream. For it is fraught with responsibilities and problems of great magnitude. However, the realization of this dream would have great meaning and value in terms of the community and the hospital it serves. But this development can never come to pass without the complete understanding, trust, confidence and support of the largest possible number in the community. Faced with an important transition period in their history with all its problems, its opportunities for service and its responsibilities, the hospitals will need a well informed and understanding public, a public which will feel a strong relationship to the hospital as an institution of service.

The Commission on Hospital Care in its splendid report pictured the future organization of community services around the hospital. It made a large number of recommendations which it hoped would contribute to the development of that picture. Some of those recommendations are quite beyond present accomplishment; some are controversial. But one of them need not wait for the future and, I believe, is essential if the others are to become a reality. It is the one which reads: "A public relations program should be maintained which will interpret the hospital to the community and relate the needs of the community to the hospital authorities."

That is a recommendation particularly worth remembering. For as the hospitals travel the road to their highest development the way will be lined with difficulties. If, however, they remain acutely aware of their public relations opportunities and utilize them, the way should become immeasurably smoother and the goal far nearer of attainment.

This is the second of two articles by Mr. Rich on public relations opportunities.

"Shades of the Past"

THE following "Hint to Hospital Administrators" was extracted from the December 1913 issue of The Modern Hospital.

"A hospital that has been using a barrel of alcohol a month cut the amount down to a barrel for four months by giving the nurses 20 per cent alcohol for rubs instead of 60 per cent. The rubbing is the thing that does the most good in alcohol rubs, though the alcohol has great cleansing power. . . ."

The advisability of reducing the alcoholic content of any liquid, not only from the cleansing but also from the stimulating standpoint, is open to unlimited arguments pro and con. Personnel shortages today also raise the question as to whether the manual labor would be available as a substitute for alcohol.

The following mixture has been used for external application since 1926 at Strong Memorial Hospital, Rochester, N. Y. It is not intended as a substitute for the manual labor exerted in the rubbing, but it has proved to be a dollar saving substitute for alcohol.

Boric acid crystals	8 oz.
Aluminum potassium sulfate	2 oz.
Camphor	1 oz.
Waste alcohol q.s.	5 gal.

Hand rinse basins in operating and treatment rooms provide the source of the waste alcohol.—Robert H. Lowe, M.D.

Formula Room

Experiment in Terminal Sterilization

ROBERT H. LOWE, M.D.

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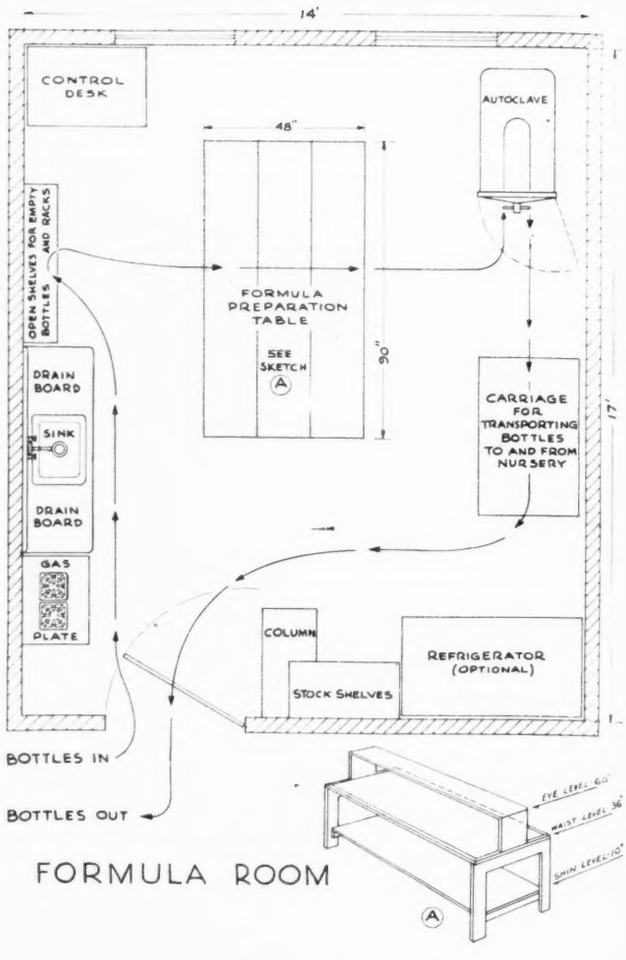


DIARRHEA in Newborn Closes Division of Hospital." Too frequently in some sections of the country this headline appears in the newspapers. The finger of suspicion is often pointed at the formula room regardless of the cause of the diarrhea.

Terminal sterilization of formulas is gaining great prominence. The following description of an experiment in terminal sterilization in one hospital is presented. The greater degree of safety to the newborn through the use of this method (as opposed to the initial sterilization previously employed) will be apparent.

The cooperation and patience of the personnel of the dietary department of the hospital and of the health bureau laboratory of the department of bacteriology of the school of medicine and dentistry, University of Rochester, in carrying out the following experiments have been of invaluable assistance and are sincerely appreciated.

Under the old procedure, formula equipment and ingredients were subjected to initial sterilization at 212° F. for twenty minutes in a nonpressure water sterilizer. These were then used to compound the individual formula, aseptic technic being observed. The bottles were capped with sterile cellophane held in place with a cardboard collar and transported to the nursery, where they were placed in the refrigerator until feeding time. At feeding time the bottle was warmed, the cardboard collar and cellophane cover were removed and a sterile nipple was applied.

The dirty bottles and nipples were washed grossly clean, placed in muslin bags and covered enamel cans respectively and autoclaved in the central supply room prior to delivery to the formula room and refilling.

A five day study was made of the formulas prepared by this method in order to determine what bacteriological growth occurred. Plate

Table 1—Cultures of Ingredients Prior to Treatment and Compounding

Formulas	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Whole boiled milk	70	60	30	20	40
Evaporated milk	1800	12000	48000	20	12000
Sterile water	10	30	0	0	0

Table 2—Results of Initial Sterilization Tests

Formulas	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Stock Formula No. 1	4400	2100	3000	50	3500
Evaporated milk 1/3					
Water 2/3					
Sugar 5%					
Stock Formula No. 2	3500	7800	12000	30	4800
Evaporated Milk 2/5					
Water 3/5					
Sugar 5%					
Stock Formula No. 4	800	30	100	6200	40
Skim milk 50%					
Whole milk 50%					
Sugar 10%					

Dr. Lowe did this work while he was administrative assistant at Strong Memorial Hospital, Rochester, N. Y.

counts were made using American Public Health Association standards (table 1).

The ingredients listed in table 1 were then heated at 212° F. in a nonpressure water sterilizer for twenty minutes following which formulas were compounded following aseptic technic.

The bacteriological results shown in table 2 were obtained on these formulas.

The public health standard is a maximum of 500 colonies per cc. for certified pasteurized milk, 30,000 per cc. for pasteurized milk and 200,000 per cc. for raw milk.

Conclusion: It was considered that a bacteriologically acceptable formula was not being produced.

The following experiment was then carried out: For five consecutive days, untreated samples of ingredients, including whole milk with a high bacterial count, were obtained and subjected to bacteriological analysis as shown in table 3.

After obtaining the foregoing samples for culture, formulas were compounded from the same stocks and subjected to two methods of terminal sterilization (tables 4, 5) with the bacteriological results indicated.

The conclusion reached was that terminal sterilization will produce formulas with a bacteriological content far below the standard for certified pasteurized milk.

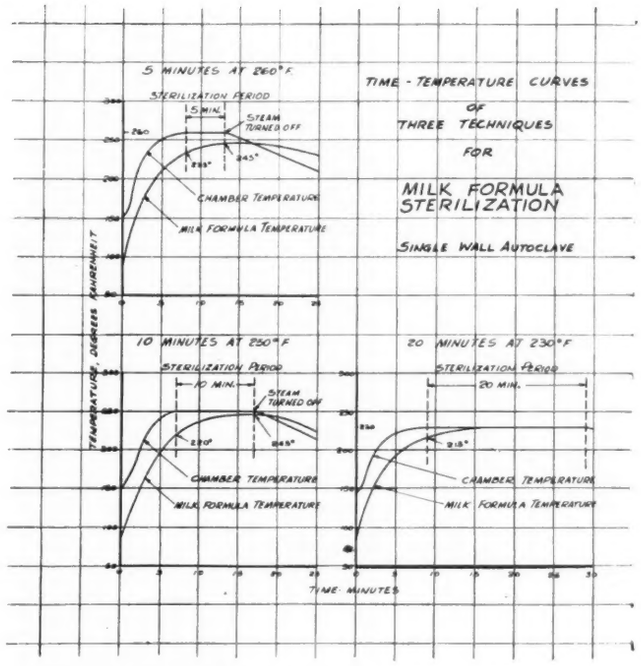


Fig. 1. Graphs showing time and temperature curves.

It was decided to do further study using the autoclaving method in preference to the water sterilizer for the following reasons:

1. Possibility of error in timing and temperature was reduced.
2. Processing was speedier both in time and in volume.
3. Draining and drying bottles after processing was not necessary.
4. Identification tags were not as easily obliterated.
5. It was possible to assemble a complete unit consisting of bottle, nipple and protective cap.

The accompanying graphs (Fig. 1) portray the temperatures the formulas reached during the varying periods of time and temperature of exposure.

A wide mouthed bottle was adopted because it could be more easily cleaned and filled.

The first few trials were made at 230° F. for twenty minutes in a pressure autoclave, a procedure that has been advocated in many articles on the subject of terminal sterilization. Difficulties were encountered because the formulas, especially Stock Formula No. 4, had a tendency to cook and plug the nipples. In fact, it was subsequently determined that this formula could not be subjected to terminal sterilization without a coat of surface "skin" that would plug the nipple being formed. Substitution of a prepared milk powder containing approximately 50 per cent skim milk powder and 50 per cent whole milk powder will probably eliminate this difficulty, according to latest reports.

Study of the temperature graphs (Fig. 1) showed that when the autoclave attained a temperature of 230° F.

Table 3—Cultures of Ingredients Prior to Compounding and Terminal Sterilization

Formulas	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Whole milk	1500	*48000	*300000	9100	21000
Evaporated milk	*500	100	0	0	0
Tap Water	8	0	2	6	20

*Presence of E. coli

Table 4—Terminal Sterilization at 212° F. for Twenty Minutes in Nonpressure Water Sterilizer

Formulas	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Whole milk and tap water	0	0	20	0	0
Evaporated milk and tap water	0	0	0	0	0

Table 5—Terminal Sterilization by Pressure Autoclaving for Ten Minutes at 250° F.

Formulas	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Whole milk and water	20	0	0	0	0
Evaporated milk and water	10	0	0	0	0

the formulas within the autoclave had reached a temperature of 215° F. and increased in temperature during the five minute exposure at 230° F. to 229° F. In short it was about the boiling point for the entire five minute period.

It was decided to work backward, to try for the ultimate at once, and regress if necessary. Accordingly formulas were prepared under nonaseptic technic, tap water, untreated ingredients and grossly clean bottles applying the nipple and protective cap. Formulas so prepared were then terminally sterilized at 230° F. for five minutes in order to cut down the "cooking" time (table 6).

The question was raised as to whether spore formers would be eliminated by this comparatively short time of processing. The samples listed were incubated for five days at 165° F. Untreated samples showed a growth of rods and streptococci, in addition to curdling, while the samples that had been autoclaved for five minutes were sterile and normal in consistency.

There are times when the foregoing method cannot be used in its entirety as:

1. Special formulas containing ingredients, as cereal, mulsoy, lactic acid, meat and the like, will bake if subjected to autoclaving temperature. These types are seldom used in this hospital, however, but may be prepared following aseptic technic with preliminary sterilization of all equipment and all possible ingredients if necessary.

2. Special feeding problems, as cleft palates and harelips, require a nipple of special size and shape. These patients also are in the minority and formulas for them are terminally sterilized, narrow necked bottles, standard sized nipples and glass caps being used. The nipples may be changed for special sizes in the nursery, when necessary.

The following possible objections were considered and dealt with as described.

1. *Cooling.* Cooling at room temperature prior to storage in the refrigerator did not injure the formula.

2. *Precipitation.* Because of the high temperature a certain amount of precipitation of proteins, which takes the form of a surface "skin" coat, occurs. Energetic shaking of the bottle after autoclaving and prior

Table 6—Terminal Sterilization of Formulas Prepared Under Nonaseptic Technic

Bacteriological Results	Standard Colony Plate Count				
	1st Day	2d Day	3d Day	4th Day	5th Day
Stock No. 1.....	0	0	0	10	20
Stock No. 1.....	0	0	0	10	0
Stock No. 2.....	30	0	10	0	10
Stock No. 2.....	10	10	20	0	0
Stock No. 4.....	40	0	0	0	0
Stock No. 4.....	0	10	10	30	0

Standards: 1. Absence of coliform organisms.
2. A maximum of 50 colonies per cc. This was set despite the assurance of the city health laboratory that a standard of 100 colonies was admissible because of the possibility of plate contamination by organisms other than from the formulas.

Table 7—Standard Colony Plate Counts Before and After Treatment

Powdered Milk Formula		Stock Formula No. 1		Stock Formula No. 4	
Before	After	Before	After	Before	After
27000	2400	140	10	52000	10
17000	50	140	0	6000	20
2800	40	110	30	14000	10
420*	50	10000*	0	11000*	30

*E. coli
Highest autoclave temperature 230° F. for one minute.
Highest formula temperature 210° F. for one minute. (Fig. 3.)

Table 8—Standard Colony Plate Counts Before and After Treatment

Powdered Milk Formula		Stock Formula No. 1		Stock Formula No. 4	
Before	After	Before	After	Before	After
31000	0	100	0	15000	0
9000	0	100	0	7000	0
190000	0	110	0	13000	30
2500*	10	380*	0	29000*	0

*E. Coli
Autoclave temperature 230°-232° F. over seven minute period.
Formula above 212° F. for twelve minutes. (Fig. 4.)

Table 9—Standard Colony Plate Count Before and After Treatment

Powdered Milk Formula		Stock Formula No. 1		Stock Formula No. 4	
Before	After	Before	After	Before	After
290000	20	140	30	11000	50
63000	50	65000	30	6800	90
70000	20	90	0	8600	90
110000*	20	55000*	30	5800*	20

*E. coli
Highest autoclave temperature 220° F. for two minutes.
Highest formula temperature 210° F. for one minute. (Fig. 3.)

Table 10—Standard Colony Plate Count Before and After Treatment

Powdered Milk Formula		Stock Formula No. 1		Stock Formula No. 4	
Before	After	Before	After	Before	After
29000	0	140	0	11000	20
120000	0	180	0	14000	0
23000	0	180	0	12000	0
17000*	0	280*	0	8400*	0

*E. coli
Autoclave temperature 220°-223° F. over eight minute period.
Formula above 212° F. for five minutes. (Fig. 4.)

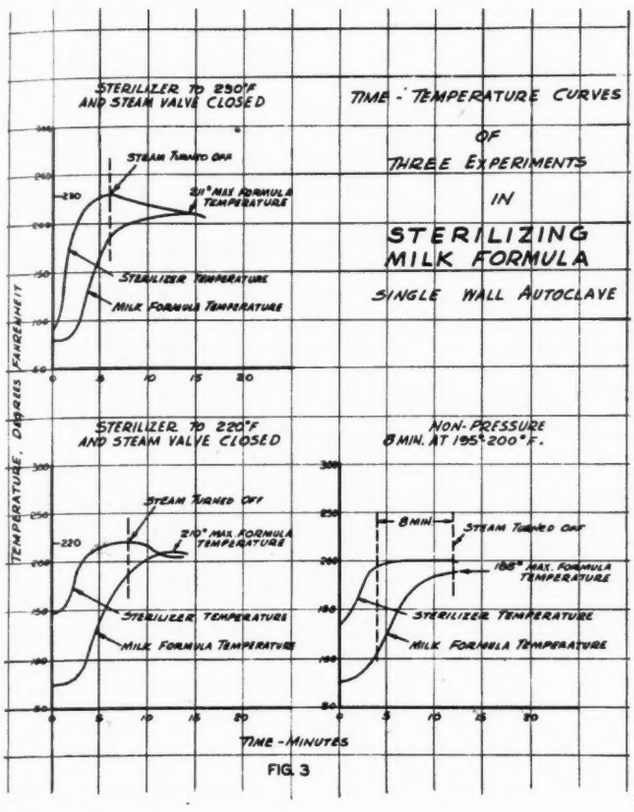


FIG. 3

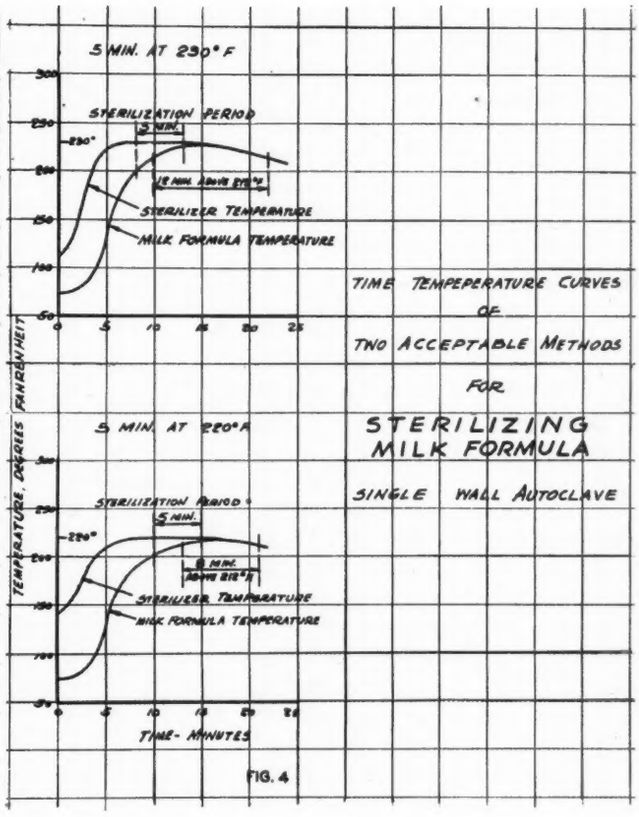


FIG. 4

to storage in the refrigerator or just after warming preparatory to feeding the infant reduces the incidence of plugged nipples from this cause. Although this problem has not been entirely solved, it is not considered serious enough to warrant discarding terminal sterilization.

In addition to the foregoing, the following experimental work was done with the bacteriological results indicated. One bottle of each type of formula was deliberately inoculated with E. coli. Clean compounding technic and grossly clean utensils, bottles and nipples were used.

1. Pressure autoclave with temperature built up to 230° F. and immediately shut off (table 7).

2. Pressure autoclave with temperature built up to 230° F. and held there for five minutes (table 8).

3. Pressure autoclave with temperature built up to 220° F. and immediately shut off (table 9).

4. Pressure autoclave with temperature built up to 220° F. and held there for five minutes (table 10).

5. Nonpressure autoclave with temperature held between 195° and 210° F. for eight minutes (table 11).

It will be noted that the bacterial counts made prior to autoclaving on formulas from powdered milk are high. These formulas were made with powdered milk from a can which had been opened some time. Tests in triplicate on a formula made from a freshly opened can gave counts of 22,000, 25,000 and 18,000 organisms per cc. It is believed that, while the high initial counts point to the advisability of using only powdered milk from freshly opened cans, the low terminal counts on these samples strengthen the evidence that autoclaving at 220° F or 230° F. for five minutes is a satisfactory terminal sterilization procedure.

Table 11—Standard Colony Plate Count Before and After Treatment

Powdered Milk Formula		*Stock Formula No. 1*		*Stock Formula No. 4*	
Before	*After*	*Before*	*After*	*Before*	*After*
35000	30	7200	0	100000	20
3900	0	80	20	7200	10
2200	0	90	0	26000	30
240000*	30	7100*	10	6000*	20

*E. coli
Nonpressure autoclave temperature 194°-210° F. over seven minute period.
Highest formula temperature, 188° F. (Fig. 3.)

Summary:

1. Terminal sterilization of formulas in a pressure autoclave at either 220° or 230° F. for five minutes will produce a bacteriologically acceptable end product.

2. It is possible to produce bacteriologically acceptable formulas with either of the foregoing procedures by using nonaseptic compounding technic, untreated ingredients, grossly clean bottles, nipples and equipment.

3. Elaborate physical plants are not necessary. (See plan on page 48.) Some 400 to 500 bottles are prepared in eight hours in this room by two women who have no training other than that required for this task.

Conclusion:

Evidence accumulated to date indicates that it is possible to compound standard formulas which may be subjected to the heat of terminal sterilization by pressure methods, that results are satisfactory bacteriologically and that the method of terminal sterilization is superior to the older so-called aseptic method of formula preparation.

JOB CONTROL Simplifies the Task of Good Management

S. S. PRESTON

ANY system involves "determining the best way of doing a thing and preventing its being done any other way." The surgeon requires that all operating room procedures follow an exact predetermined pattern and permits not the slightest deviation therefrom. And the business manager installs an accounting system best suited to the financial administration of his enterprise. Basic records, accounts, reports and balance sheets are prepared according to a set of prescribed rules of procedure by a clerical staff under the supervision of a chief clerk.

This chief clerk is not authorized to alter the mechanics of the accounting system without executive approval. The surgeon systematizes operating room technics in order to prevent errors and loss of time which may cost a life. The executive who employs methods of carefully regulated procedures and prohibits unauthorized deviation is relieved of the encumbrance of detail matters and yet maintains finger tip control of the organization for which he is responsible.

Poor System Does Harm

The advantages of a job evaluation and job control system to management and the technics which may be employed in determining the relative worth of jobs have been discussed in previous articles of this series. Obviously, a poor system will do more harm than good, and a good system carelessly administered is equivalent to the ill conceived system. This is particularly true of the job control system, since it plays such an important rôle in defining and administering policies governing functional departmental relationships, wage administration and the analysis and control of labor costs. However well jobs are analyzed and evaluated the product is worthless unless a system of control is formulated and administered without diminished enthusiasm and interest on the part of management.

In this series of articles I have attempted to illustrate as clearly as possible within the limitations of space the application of a job evaluation and job control system to progressive and efficient hospital management and some of the resultant advantages. I have avoided carefully any implication that from this material the "novice" can build his own system safely. In fact, I recommend strongly against any such attempt. I am confident that any reputable industrial engineer will support my assertion that, as with the installation of accounting or other systems, the institution of the job control system should be entrusted to experienced specialists.

It is recommended that a job control supervisor be appointed at the time of the employment of the industrial engineer if the hospital is a reasonably large one. The individual who is chosen to function as the job control supervisor should have a sound knowledge of industrial practices and possess the native ability to mix well with all personnel of the institution. A background of job analysis, job evaluation or job control is not requisite. In fact, it is preferable that such a background be absent. It is the responsibility of the engineer to instruct the job control supervisor in all of the processes and technics required for intelligent installation and administration of the system so that when the installation is complete and in operation it can be carried on successfully by personnel of the institution.

The primary function of the job control supervisor is to assist the committee members and the various department heads with any problem or any matter pertaining to the evaluation of jobs or job control. He prepares all job control cards (except scoring degrees of intensity of evaluation factors, a function of the committee) and the majority of the basic job analysis forms. It is his responsibility to provide the committee with analyses, reports, charts and diagrams as required for the rapid and proper discharge of its administrative responsibilities.

The job control supervisor acts as a liaison officer between the committee and departmental supervisors, assisting them with organizational and administrative problems, and recommends to the committee improvements in job or departmental structure and relationships. By way of justification of the labor cost of such a job, if through the efforts and abilities of the job control supervisor three unnecessary jobs are eliminated annually the resulting saving will justify his salary.

There is serious doubt that the smaller hospital can afford to employ a job control supervisor and must therefore add many of the functions of the job to that of the administrator or of the manager. In such cases more direct assistance of each department head should be solicited.

A job control system may be built with the following specific objectives in view:

1. To maintain continuous executive control of labor costs.

2. To ensure the payment of wages to personnel commensurate with the responsibilities, requirements and other characteristics of

A summing up of the procedures to be followed in building and managing the job control and evaluation system described in the preceding articles in this series, which appeared in the December 1946, and February, May and June 1947 issues

jobs and according to the relative worth of jobs.

3. To maintain uniform standards for selection of personnel for jobs.

4. To maintain logical lines of promotion or transfer of personnel.

5. To contribute to efficiency of operation by forcing continuous and objective analysis of all operating procedures as related to the functions of jobs.

In the course of this series of articles frequent reference to the job control committee has been made. Not only does the committee evaluate all jobs but it is responsible for the administration of all aspects of the job control system. It recommends to general management for approval policies and procedures necessary to achieve the objectives of the system and governs the practical application of such policies and procedures. No job may be changed, eliminated or created except upon review and approval by the committee. It administers all wage payment policies. All matters pertaining to the functional relationship of departments or divisions come within its purview. It bears full and inescapable responsibility for the objective and uniform administration of wage payment. If excessive or unnecessary wage costs develop, the committee is answerable to management therefor.

It has been suggested that the hospital job control committee be composed of a representative of the board of directors or trustees, the administrator or manager, a staff physician, the personnel director (if any) and the supervisor of nurses. Here will be represented the diverse managerial and supervisory interests which must act in unified accord in the broader interest of the institution itself. This welding together of normal diversity of concepts for the good of the institution is a highly important, although secondary, reason for the recommended membership.*

At first glance it would appear that the execution of the functions of the committee would demand continuous session and thereby prohibit such strong membership. Fortunately, one or two meetings each month are sufficient for the well trained committee to dispose of accumulated business.

The process of the evaluation of jobs, the first all inclusive survey and analysis, is time consuming and difficult work for the committee. But having evaluated every job within the organization and so having become thoroughly familiar with jobs and functional organizational structure and having assisted with the development of administrative policy, the committee member finds it a simple task to make rapid and accurate decisions.

It must be remembered, too, that the members of the committee must have the support of the various department heads and, if the size of the institution so warrants, that of a full time job control supervisor. The committeeman is not expected, and should not be permitted, to provide himself or the committee with data necessary to making decisions. Procedures are established whereby such data are accumulated by subordinate personnel in uniform and concise form for presentation to the assembled committee.

A job control system which is not understood by department heads and which does not receive their enthusiastic support is fundamentally weak.

*Acting as a member of a committee which is charged with such heavy administrative responsibilities leads one individual to develop understanding of and mutual respect for the attitudes and problems of the other committeemen. Although physicians, as a rule, do not interest themselves in the details of administration, it is considered desirable that at least one of this professional staff be thoroughly conversant with the administrative problems which arise from day to day and to have a voice in the solution of such problems.

Although the department head (except as recommended above) is not a member of the committee, he attends all meetings in which the jobs of his department or wages of the personnel whom he supervises are to be acted upon and he is invited to express his opinions freely and without duress. He has also played an important rôle in the initial analysis and evaluation of the jobs for which he is responsible. Either he has assisted the job control supervisor in preparing the basic job analysis forms for such jobs or he has prepared them himself and he has been present during the final evaluation of the jobs.

Must Not Be Dictatorial

The department head is invited to recommend to the committee any changes in jobs or functional relationships which may serve to increase efficiency or to reduce the cost of operation of his department. He is responsible to the committee for carrying out all procedures pertaining to the job control system applicable to his department. Although the committee does wield administrative authority it must not be dictatorial in action. Cooperation and mutual assistance and confidence are absolutely essential!

Although specific job control policies and procedures must be developed and applied according to the dictates of the management of the institution in which the system is being installed, I present below a few representative policies purely for the sake of example.

1. No salary will be paid to any individual whose job has not been evaluated and approved by the job control committee. Any exception shall be approved in writing by the chairman of the board of trustees.

2. The job control committee is expected to discover and to correct salary inequalities or maladjustments before complaint is initiated by personnel.

3. Department heads are encouraged to request reevaluation of jobs in the interest of increased efficiency or productivity.

4. No salary paid to any individual will be less than the minimum salary of the group in which his job is classified nor will it exceed the maximum, except for: (a) learners on a job who may be paid a salary within the group immediately below that of

the job until occupationally qualified for the job; (b) employes to whom financial recognition is given for unusually meritorious service. Such employes may be paid salaries above the maximum of the group in which their jobs are classified. Such exceptions must be approved in writing by the chairman of the job control committee.

5. No salary or wage of any individual on the pay roll at the time of the evaluation of all jobs will be reduced as a result of the evaluation.

6. Creation of personality jobs will be avoided wherever possible and, if created, flagged for elimination when practicable.

In building and managing a job control system the following schedule is adhered to chronologically in the order given:

1. Obtaining the services of an industrial engineer or industrial engineering firm specializing in the field.

2. Employing a job control supervisor or making available to the industrial engineer the necessary time of the administrator or manager.

3. Creating the job control committee.

4. Instructing all department heads as to: (a) reasons for the installation of the system; (b) their rôle in its initiation and subsequent administration.

5. Informing subordinate personnel concerning the broader aspects of the program in order to prevent the development of erroneous concepts.

6. Preparing a basic job analysis form for every job subject to analysis and approval of each by the supervisor directly responsible for the job.

7. Preparing job control cards for each job by the job control supervisor or by an individual acting in that capacity.

8. Obtaining approval of the job control card as accurate by the responsible supervisor.

9. Preparing a wage scale for managerial approval.

10. Evaluating all jobs by the job control committee, assisted by the job control supervisor and the various responsible supervisors.

11. Reevaluating those jobs that were changed in the interest of sound relationship and efficient operation during the evaluation procedures.

12. Formulating policies and procedures governing the subsequent administration of the system for managerial approval.

13. Instructing supervisory personnel concerning policies and procedures and its job control duties and responsibilities.

14. Informing subordinate personnel of the manner in which it is affected by the system.

15. Classifying personnel according to established jobs and planning a long range program designed to bring all salaries or wages into line.

16. Administering progressively the job control system by the job control committee.

The importance of creating confidence of all personnel in the system cannot be overemphasized. It must be so administered as to merit continued confidence of employes and executives alike. Underlying all actions and decisions of the committee there must be a foundation of absolute fairness and objectivity of purpose.

To initiate and to build the system is not an easy task. To administer it is a matter of relatively simple routine.

Both Mr. York and I hope that this series of articles has served in some degree to arouse interest of executive personnel of hospitals in one of the tools that is employed successfully by progressive industrial management. No system is strong enough to cover the deficiencies of poor management in any enterprise but to reduce repetitive functions to systematic control supports and simplifies the task of good management.

Advantages of Consolidation

CONCORD Hospital, which is a combination of Margaret Pillsbury General Hospital and New Hampshire Memorial Hospital, Concord, N. H., is beginning to experience the benefits of joint operation of the two units under one management. Each of these units has approximately 80 beds and up to June 1, 1946, was run as an individual hospital, often with conflicting ideas and policies.

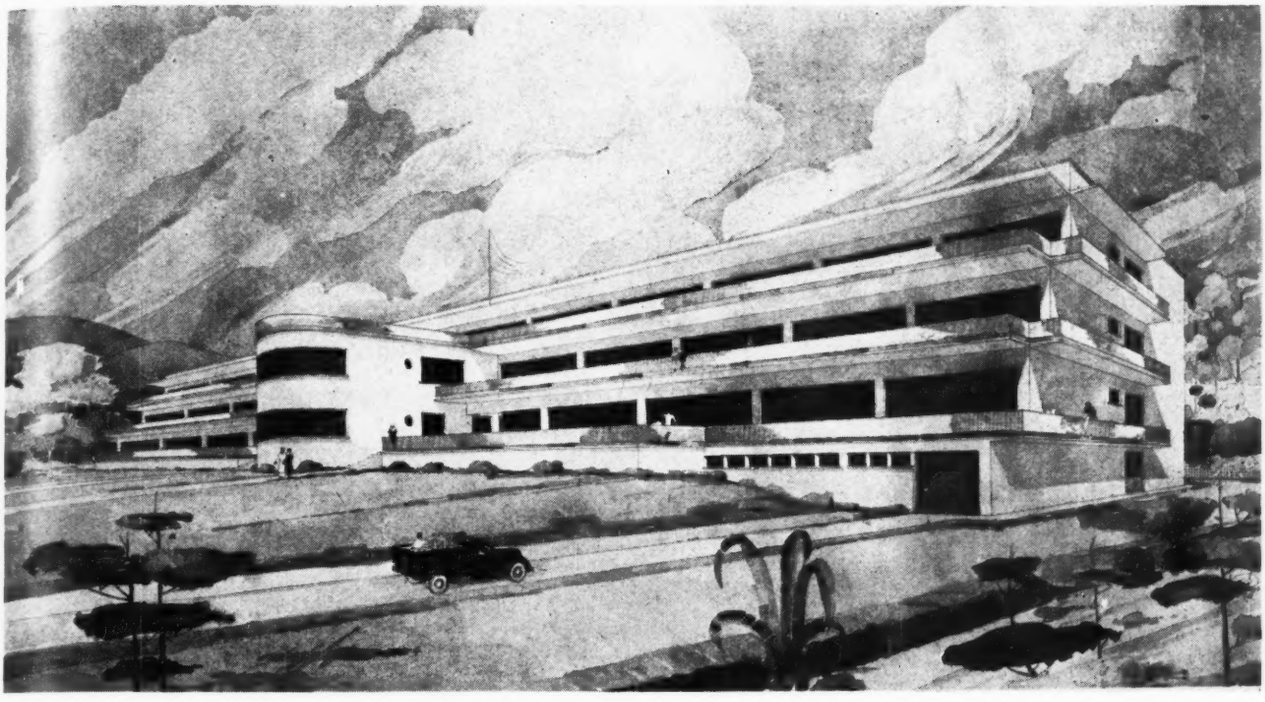
Since June of 1946, the staffs of the two hospitals have been combined into the staff of the Concord Hospital and have set up a staff organization. The Concord Hospital School of Nursing replaces the schools of the two units, and well qualified instructors and supervisors have been attracted by the increased size of the school and by the fact that the hospital school, because of its larger student body, is able to pay better salaries.

A central admitting office for the booking of patients and the planning of operations in both units has been developed. This saves a great deal of the doctors' time in calling for admission and operating room time. A registered pharmacist has been appointed who supervises the drugs and the pharmaceutical preparations at each unit. He divides his time between the two units and fills the prescription orders and the drug baskets.

An executive housekeeper coordinates the housekeeping responsibilities in each of the units. A superintendent of works and grounds has been appointed who has attracted a crew of painters and carpenters, plumbers and millwrights who are doing the maintenance and repair work at both units at a considerable saving as against the charges to the individual hospitals from private contractors in the past. Laundry operations are carried on under the supervision of a laundry manager at one of the units with the clean linen being transported to the other unit by truck. An improvement in the quality of laundry work with resultant longer life of linens with a smaller crew of laundry workers has more than justified the increased salaries that are being paid to the workers. A plan is afoot for the consolidation of all linen disbursements from a central linen room situated in one of the units, the linen to be sent directly in the baskets to the floors of the other unit.

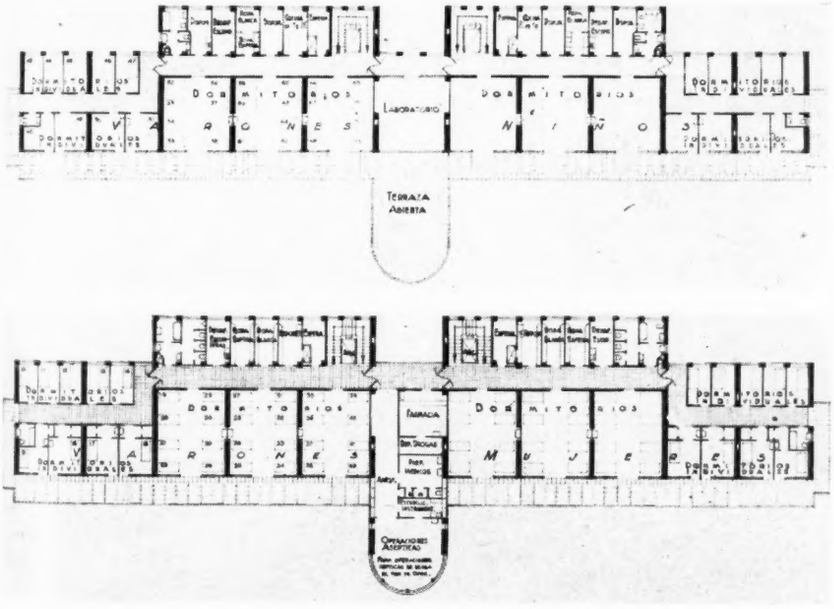
All of these things are made possible through the consolidation of the two hospitals. The patient load of neither of the former units alone would have justified employment of people of this caliber and such forward-looking practices as it is now possible to put into effect.—N. CONANT FAXON, *administrator, Concord Hospital, Concord, N. H.*

Bolivia Majors on Modern Hospitals

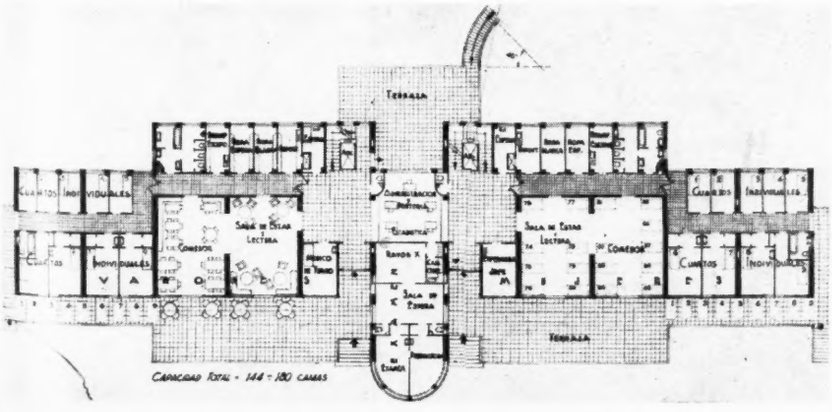


Tuberculosis Hospital, La Paz, Bolivia. Main entrance and front of building.

ZOLTAN S. PAJOR
Director of
Hospitalary Architecture
Ministry for Public Health
Bolivia



Below: Plan of the main floor. Above: Second and third floors showing the operating room on the second floor and the open terrace above it.

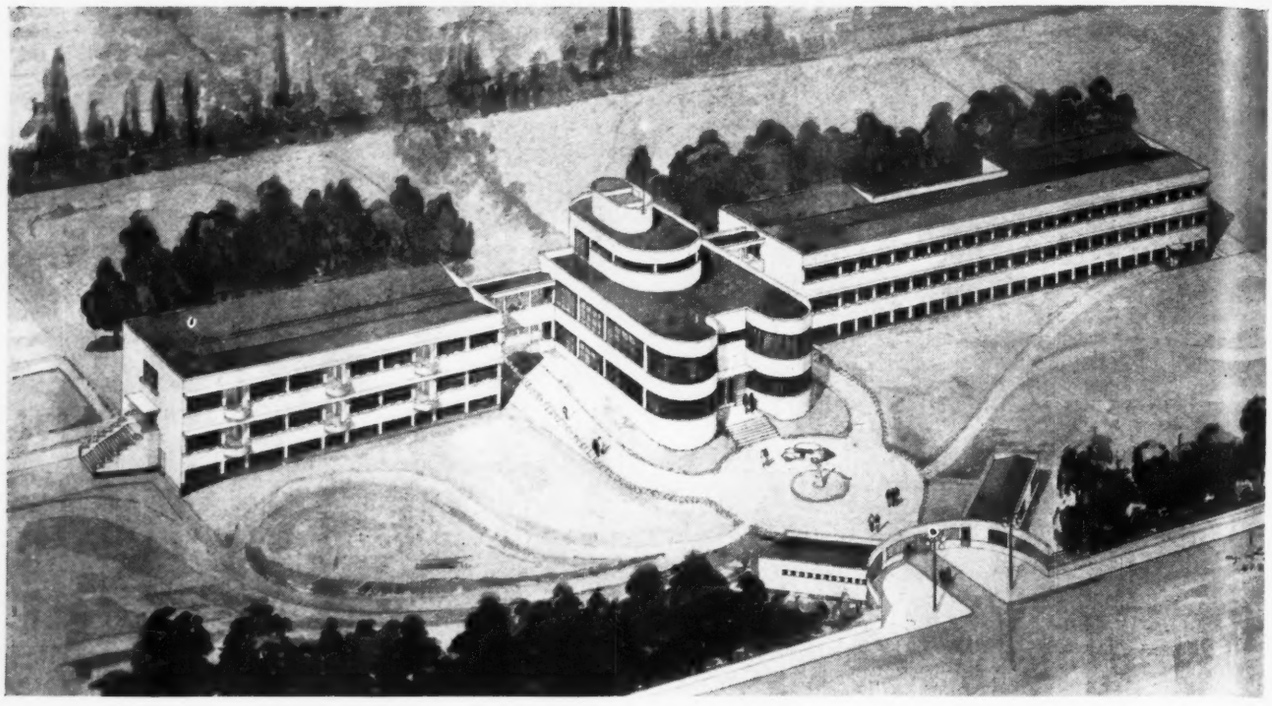


Tuberculosis Hospital
La Paz, Bolivia

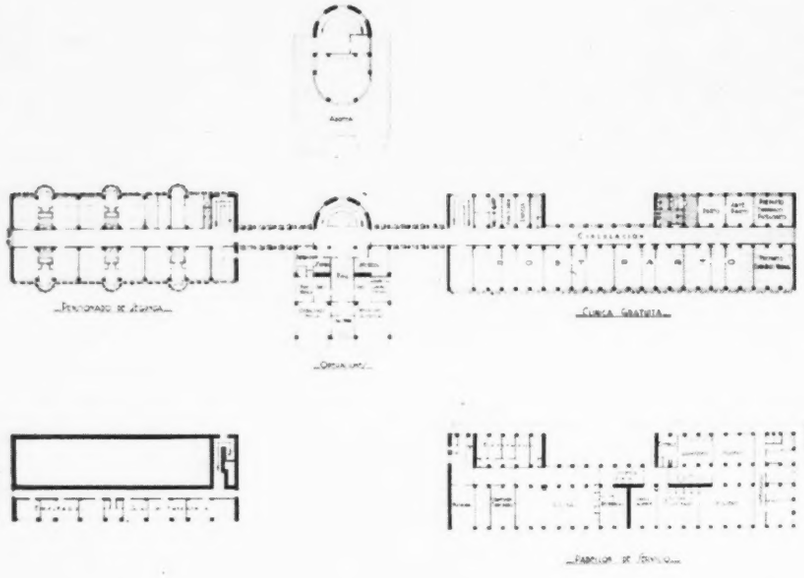
LA PAZ is Bolivia's first city with a population of 300,000 and is at an altitude of 12,000 feet above sea level. The climate is notable for hot days and cold nights. The Tuberculosis Hospital is Bolivia's first modern sanatorium and is being built by the Ministry for Public Health.

When completed, this hospital will have a bed capacity of 180 beds. The patients' rooms have large terraces for purposes of rest, each a step behind the other so as to permit the maximum amount of sunshine possible. The sanatorium is located on the grounds of the General Hospital but has a complete service of its own.

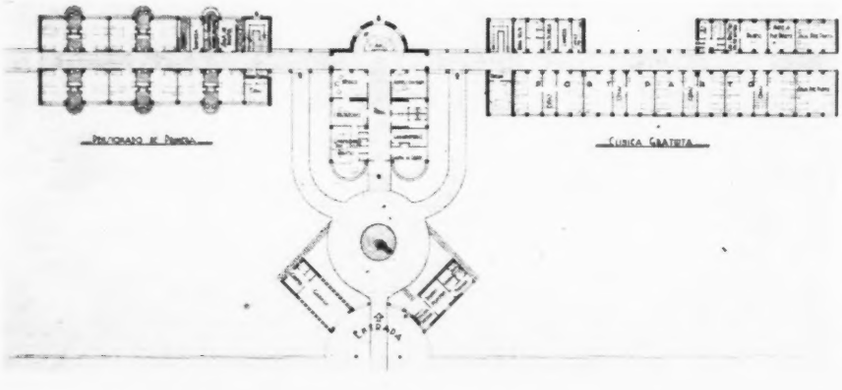
The foundation of the building is concrete, with walls of stone and concrete blocks; slabs and floors are of reinforced concrete. An additional $175,000 is needed to complete the job. (Work so far has cost approximately $100,000.) It is interesting



Architect's rendering of the Maternity Hospital, Cochabamba, Bolivia.



Below: Main floor of the Maternity Hospital, which has 104 beds and 85 bassinets. Above: Plans of basement, second floor and amphitheater.



to note that each floor is a series of setbacks to provide maximum sunshine.

Maternity Hospital Cochabamba, Bolivia

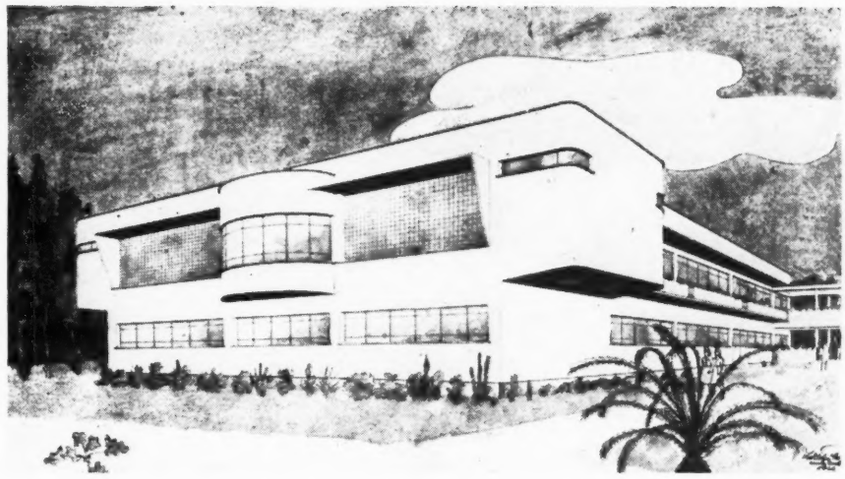
COCHABAMBA is Bolivia's second city, with a population of 80,000 in the city itself and 100,000 in the suburbs. It is 8000 feet above sea level and has a climate comparable to that of California. Bolivia's first modern maternity hospital is being built there by the Ministry for Public Health. Although situated on the grounds of the General Hospital, it is separated from it by an avenue.

The hospital has a capacity of 104 beds and 85 cribs; this capacity can be increased by 10 per cent by making use of the emergency rooms. The building is divided into three sections: (1) rooms for private and ward patients; (2) consulting rooms for prenatal and postnatal patients, social service, administration and operating rooms; (3) clinic and service areas. The three groups are independent but at the same time closely interrelated. The foundation of the building is stone and cement mortar, with walls of brick and slabs and floors of reinforced concrete.

It is interesting to note the new solution for wards and nursery. The

nursery is situated between two wards in such a way that the mothers can see but not touch their newborn babies by looking through glass walls which separate them. The nurses have a special entrance from the corridor and during each nursing period the doors to the ward are opened.

To finish the building, which has been delayed because of a shortage of materials, will require $140,000 as building costs in Bolivia are extremely high. (To date the cost has been about $138,000.)



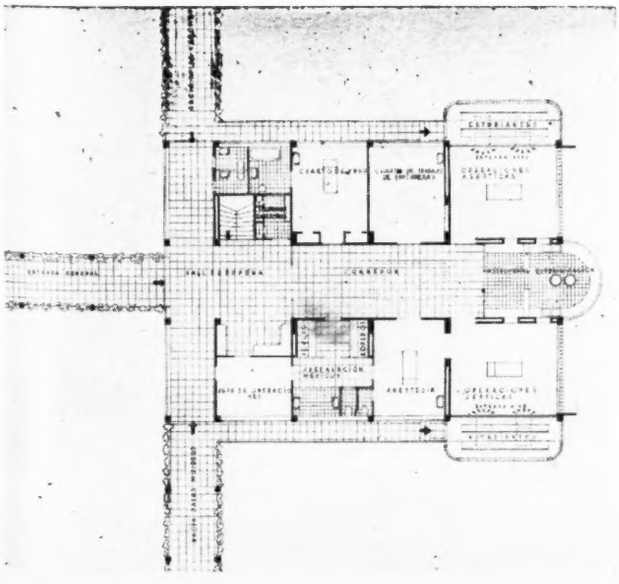
Above: Artist's rendering of the operating pavilion of the General Hospital at La Paz, and, below, as the finished structure appears.

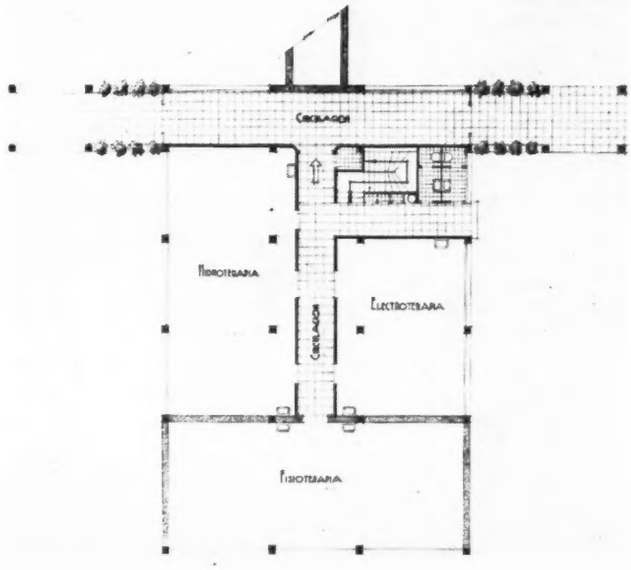
Operating Pavilion General Hospital La Paz, Bolivia

THE operating pavilion of the General Hospital at La Paz is located between two old surgery pavilions built by the Ministry for Public Health. It is constructed of reinforced concrete; a large amount of glass block is used in the walls. The operating rooms are to be air conditioned.

It will be noted that students of medicine can enter the observation gallery from an outside corridor without disturbing the internal service of the building. Fenestration and ventilation are completely separated in the design.

Below, left: Layout of the surgery, showing clean and dirty operating rooms, with sterilizing room between; anesthesia room; doctors' preparation room; nurses' workroom, and gallery for students. This gallery can be approached from a corridor outside the building. Below, right, Hydrotherapy, physical therapy and electrotherapy rooms.





How Emergency Nursing Service Will Be Handled

If a Polio Epidemic Breaks Out

THE American National Red Cross and the National Foundation for Infantile Paralysis have adopted the following procedures for emergency nursing service during outbreaks of poliomyelitis.

Recruitment. The need for nurses will be determined by a local advisory committee, organized by the local chapter of the national foundation in consultation with the state representative, to be composed of: hospital administrator (one or more); health officer (state, county or city); representative of American Red Cross local chapter; representative of county or district nurses' association; representative of national foundation's local chapter; state representative of national foundation; representative of county medical society, and representative of the American Physiotherapy Association.

In the event of an increase of infantile paralysis cases requiring emergency nursing personnel, the American Red Cross local chapter will recruit nurses upon request from the state representative of the National Foundation for Infantile Paralysis, who will clear with the Health Officer (state or county). Registered nurses with previous polio experience or special training are preferred.

Employment. 1. Nurses recruited by the American Red Cross for polio nursing will become employes of the hospital or institution for which they are recruited. Neither the National Foundation for Infantile Paralysis nor the American Red Cross employs the nurses recruited for polio nursing. The national foundation's chapters are authorized to reimburse the hospital for the nurses' salaries.

2. Nurses recruited from outside the community should agree to work for a minimum of at least one month. If nurses leave their assignments of their own accord before that time, they will be paid through the last day of service. If nurses are released by the hospital prior to that time, they will be given one week's notice before the termination of their assignment or the equivalent amount of pay.

Supervision. 1. The American Red Cross will provide field nursing supervisors wherever possible to coordinate recruitment, assist in arranging maintenance and orienting recruited nurses to hospitals.

2. The American Red Cross will try to recruit nurses with supervisory experience or special training when hospitals cannot provide adequately trained or experienced supervisors.

3. Consultants from the Joint Orthopedic Nursing Advisory Service will be made available under funds from the National Foundation for Infantile Paralysis to supervise, give in-service training courses, assist in orienting nurses to hospitals and correlate nursing and physical therapy services where necessary. Requests for the services of these consultants may be made by the local advisory committee or the hospital administrator through the national foundation's state representative to national headquarters.

Salary and Hours of Work. 1. A monthly salary of $250 will be paid for 48* hours per week to all nurses, except supervising nurses, recruited by the American Red Cross for nursing infantile paralysis patients during the isolation or convalescent period, and $275 will be paid for supervising nurses.

2. Payment of salaries will be made by the hospital or institution in accordance with the regular pay period for nurses in that hospital, salary to start on date nurse reports to hospital for duty.

Maintenance. 1. Maintenance, to include lodging, meals and laundry of uniforms, will be provided for nurses recruited from outside the community by the hospital or institution, wherever possible. The national foundation's chapters are authorized to reimburse the hospital for the actual cost of such maintenance but the sum shall not exceed $75 per month.

2. If maintenance cannot be provided by the hospital, payment to the nurse for maintenance in the community will be made by the hospital not to exceed $75 per month. The national foundation's chapters are authorized to reimburse the hospital for the cost of such maintenance.

3. Maintenance will be arranged in advance of the nurse's arrival by the hospital and local chapters of the American Red Cross and the National Foundation for Infantile Paralysis.

4. When local nurses are employed in an emergency or epidemic situa-

*We are aware that the American Nurses Association has recommended an eight hour day, 40 hour week, and we endorse that recommendation. But the nursing shortage and the emergency nature of infantile paralysis make it impossible for a 40 hour week to be put into practice this summer. Therefore, at present, we are basing the salary on the 48 hour week with the understanding that the transition to a 40 hour week will be made as soon as possible without any reduction in salary.

tion, the hospital will provide one or two meals per day, whichever is customary. No other maintenance is to be provided.

Travel Expense. Travel expense from the place of recruitment to the place of assignment will be paid by the local chapter of the American Red Cross which is responsible for recruiting the nurses.

2. Return travel expense from the place of assignment to the place of recruitment will be paid by the local chapter of the American Red Cross at the place of assignment.

3. Such travel expense will include: cost of plane or train accommodations plus an allowance of $10 per day while traveling in lieu of salary and expenses, such as meals en route, taxi, tips, baggage costs and travel insurance. In addition, the cost of hotel room, if necessary, between train or plane not to exceed $4 per day will be allowed.

4. The American Red Cross will be reimbursed for this travel expense by the headquarters office of the National Foundation for Infantile Paralysis.

The College of Surgeons Surveys the Nursing Situation

THE nursing shortage is easing perceptibly in a substantial number of hospitals, the American College of Surgeons has reported in publishing the results of a nationwide survey of more than 1000 hospitals.

The report, which has just been issued following a questionnaire survey of nursing practices, indicates that the nursing situation is "either entirely satisfactory or shows signs of becoming so in the near future" in approximately 100 of the responding hospitals. These hospitals "have a sufficient number of graduate nurses and no vacancies in their next class of student nurses," the report states.

Approximately 80 per cent of the 1000 hospitals from which information was received in the survey are utilizing adjunct nursing personnel of one kind or another. Many of the hospitals (610) use nurse's aides who have received from ten to forty hours of training; 230 use nursing attendants who are trained on the job but are given no formal preparation; 120 are using practical nurses who have received formal training lasting from nine to eighteen months.

An additional 67 hospitals report that some other type of adjunct nursing personnel is employed. Twenty per cent of all the hospitals are now offering nurse's aide training and 60 per cent favor the establishment of such hospital training programs. Only 4 per cent of the hospitals are training practical nurses; however, it is pointed out that this figure is not truly indicative of the number of practical nurse training programs in operation, since this information was not requested in the survey but was volunteered by the responding hospitals.

Ten per cent of the hospitals specifically disapprove the establishment of training programs for adjunct nursing personnel. The reasons given by those not favoring training programs include: inability to obtain instructors; sufficient supply of student nurses; inability to employ adjunct nursing personnel; availability of former volunteer aides who are already trained, and unwillingness to train aides in the same institution in which student nurses receive training.

Restrictions May Be Relaxed

The college report indicates that rulings by some of the state licensing authorities against training professional and practical nurses in the same institution are likely to be relaxed during coming months. The report quotes a recent publication of the joint committee on auxiliary nursing of the national nursing organizations, indicating that practical and professional nurses may be trained acceptably under the same hospital auspices provided that separate faculties and appropriate classroom facilities are available for both groups.

"It is important that the names of the two schools be entirely different in order to avoid confusion in the mind of the public," the nursing publication states. "Practical nursing schools may contract for essential clinical experience with institutions or agencies where professional nurse students are being trained. There should be no exploitation of one group for the sake of the other."

The college report emphasizes the fact that only a negligible number of nurse administrators expressed opposition to any type of auxiliary nursing personnel.

Another section of the college study presents the results of detailed analyses of requests for nursing service by patients during a single twenty-four hour period in two hospitals. Of 35 specific types of requests reported in this study, only five had to be referred to a graduate nurse.

Still another section of the report presents the content of hospital aide training courses now in operation in several different hospitals. The course at Ball Memorial Hospital, Muncie, Ind., for example, is divided into 12 sections, including ethics, care of patients, bed making, baths, back rubs, temperature, pulse and respiration procedures, perineal care, feeding, enemas, heat lamps, dressing babies and applying binders.

Fifty hospitals submitted outlines of nurse's aide training programs. Many of these are limited to on-the-job training and supervision today, but it is indicated that classroom instruction and lectures may soon be added. Those reporting classroom work now indicate that most courses are running from twenty to forty-five hours. While the college does not initiate training programs for hospital personnel, copies of the programs now being used in other hospitals are available at college headquarters.

Recreation Rounds Out the Curriculum

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THE School of Nursing of Long Island College Hospital, Brooklyn, N. Y., views instruction in health, physical education and recreation as an important aid in developing the student nurses' emotional, mental and physical health. These components of the personality are significant, for a nurse's work can absorb so much mental and physical energy that she must have a variety of interests to keep fresh for her professional duties.

It is necessary to create an understanding in the student that her great value lies in the possession of a well rounded personality alive to a world of well people and their activities. Also, the student must realize that only by maintaining and replenishing her own forces can she share her drive and lend courage to the human beings in her care.

The well rounded personality is the product of inner satisfactions derived from social approval achieved from having done something worth while and from being the center of affectionate interest of a group or of some one person. The program of the entire department is planned to contribute to such development.

The particular health areas under consideration here consist of the orthopedic examination, an evaluation of bone structure in relation to body balance and the technics of relaxation. The orthopedic examination checks on the alignment of the body's three masses of weight, any deviation of bony parts, the strength and weakness of the general musculature and the straight ahead position of the feet in standing and walking which ensures the correct mechanical articulation of the weight bearing joints.

The technics of relaxation are practiced to reduce tensions, both mental and physical. These include habits of directing thoughts from worrisome subjects to constructive subjects and methods of resting which give a quick pick-up in energy. These phases of health instruction have a decided bearing upon the student's personal appearance and upon her sense of well being.

An appraisal of body carriage, should there be a remediable defect, is reassuring to the student because

she has definite knowledge about herself and information as to what to do. Also, she realizes that by acting on such advice she is increasing her social acceptability. The reduction of fatigue improves the emotional balance since rest restores nerve energy.

Physical education and recreational activities merit an hour a week taken from ward duty. These activities are elective and there are two sections of each activity so that should the student's weekly change of schedule prevent her from attending her usual class she can choose the other section.

In the fall archery, field hockey, swimming; elementary, intermediate and advanced tennis, badminton and volley ball are offered. The winter activities are American square dancing, basketball, beginning and experienced bridge, modern dance, swimming, applied calisthenics, technics of relaxation and small games. The small games course includes ping-pong, deck tennis, badminton and card games.

The card games are selected to help the nurse in the domain of the patient. A nurse on private duty may have to divert the members of the family. Games of easy organization permitting eight or 10 players answer this need.

The spring season calls for outdoor activities again, and they are the same as those of the fall with the addition of soft ball and the omission of field hockey. Along with the objective—acquiring enough skill so that the student will continue her interest and participation in sports—there is the increase of social opportunity owing to the acquisition of sport skill. The broader the student's social experience, the more effective is her personality.

Extracurricular activities in the field of recreation are planned according to the needs and interests of the students. The student body, organized along democratic lines, is in full charge. Here, again, personality development is considered: leadership opportunities, working with a group, making decisions and plans and carrying them through to completion. A variety of social experiences prepares the student for the environment of the patient and also offers many occasions for pleasant associations with men.

A student recreation planning board, made up of the presidents of all the classes and the president of the student council, meets every three months to discuss the suggestions from the various classes and individual class members in regard to social events and the like.

The student recreation committee is composed of the board of directors of the women's athletic association and two representatives from each class. This committee is responsible for the organization, administration, publicity and finances of all recreational activities.

The actual administration of events is carried on by the excursion committee, the recreational games committee, the social activities committee and the nonathletic events committee.

The excursion committee arranges any trips away from the hospital, such as boat trips, beach parties, bicycle picnics, roller skating parties and bowling parties.

The recreational games committee organizes tournaments in tennis, ping-pong and soft ball. The twilight soft ball games with student nurses and medical students mixed on each team have been quite successful. Card parties are also in the realm of this committee.

The social activities committee plans the dances for the student body and also garden parties and teas and assists the recreational games committee with the card parties.

The nonathletic events committee has a broad program to develop. The scope includes cultural pursuits, dramatics, hobbies and music.

A faculty advising committee meets several times a year to discuss recreational facilities and the purchase of large equipment and to provide any necessary leadership.

An eight hour orientation course in health, physical education and recreation was given to the preclinical students for the first time last fall. The course is for the purpose of acquainting the student with the "why's" of physical education and recreation and the democratic structure of the organization as a whole.

The course consists of class discussion and units of study which bear on desirable character traits and of instilling practices which are inherent to the well rounded personality. It is conducted on the latest principles of group guidance and encourages participation in committee work in the extracurricular activities of the school, thus presenting a wealth of opportunity for practical application of the students' knowledge.

Opposite page, top: Spring and fall find the students getting the range on the archery target; bottom: new athletic association officers plan their spring program. Right: New students are measured for uniforms.

Not for the Indigent Alone—

Private Patients Need Social Work, Too

MANY hospital administrators and doctors are aware of the important contribution the medical social worker makes to the clinic and ward patient because of her ability to see the patient as a person, to help with social problems affecting his illness and to enable the patient to follow the doctor's recommendation. Through the interpretation of her social findings to the physician, the social worker enables him to understand better the personality of his patient as it affects the patient's attitude toward and adjustment to his illness.

How many hospital administrators and doctors have thought of the social worker as being equally helpful in regard to the private patient in the hospital? Is the limited use of the social worker in this area related to the belief that private patients, because they are supposedly financially secure, do not have problems? Is it that we still have not grown away from the idea that the social worker is acceptable only to the indigent?

One Social Worker's Answer

Perhaps some of these concepts can be answered by analyzing the activity of one social worker in relation to services offered to private patients. I was the social worker from September 1942 through August 1945 in the obstetrics division of the Jewish Hospital of Brooklyn. Of necessity, because of the large case loads and limited staff, this department concentrated assistance on the ward and clinic patient.

The administrator, however, indicated that the social service department would also act as a consultant to any physician in regard to a private patient with a problem for whom the doctor was seeking help. In many cases, because of the complexity of the situation, the department voluntarily accepted responsibility beyond consultation. I noted with interest that as the doctors became more aware of the way in which the social worker could be of help to them and to their patients they called on her more and more.

On the obstetrics service from January through December 1944, 37 private patients were served, and from January through August of 1945, 24 patients. These 61 cases came to my attention from the following sources: 30 cases were referred by doctors (the greatest proportion); 16, by patients or members of their families; seven, by nurses; eight, by community agencies, such as the Red Cross, department of health, private family and public assistance agencies.

What were the problems for which these patients were referred?

Fifteen cases were those of women with home problems, such as the need for a housekeeper, marital difficulties and other emotional problems.

Thirteen cases involved requests for placement of children. In some cases, mothers had no one to care for their other children during their confinement. In other instances, because of the patient's home situation, she was not able to take her baby home with her. In addition, it was necessary to find placements for children found to be abnormal at birth.

Ten patients were unmarried mothers for whom plans had to be made for their future, as well as for that of their infants. These girls are usually upset and find it difficult to reach a decision during their short stay in the hospital. Thus, they need the skillful handling of a trained social worker who is sensitive to the implications of their statements and who can help them clarify their own thinking. Many physicians are aware of the involved nature of such a problem and thus bring these cases to the attention of the social worker as early as possible in the pregnancy.

Nine families wished information as to how to adopt a baby. Most of these were referred by private doctors. These doctors had become aware of the dangers involved, in arranging private adoption, for the baby, for the mother wishing to give her baby away for adoption and for the adoptive parents. The doctors asked us to interpret to their patients the benefits involved in obtaining a baby through a recognized adoption agency.

Six cases were women who requested that their husbands be sent home on furloughs.

Six involved requests for general information regarding resources in the community, frequently involving other members of the family rather than the patient.

Two needed the services of a visiting nurse.

The following case illustrations will exemplify the way in which the social worker was of help to private patients.

The Case of Miss Long

In August 1945, Miss Long, an attractive 19 year old girl, unmarried, asked to see the social worker. She was going to give birth in September after which time she would have to go to work and would have no one with whom to leave the baby. What could she do and how could the social worker help her? Could the social worker find a place for the baby?

Miss Long was Protestant, her child's father was Catholic. Their families did not approve of their marrying, but they had been fond of each other and had gone out together for three years. They had finally decided against marriage and had ended their relationship. Soon after this separation, Miss Long learned that she was pregnant. She would not consider marriage, yet she wanted to keep the baby. Although her family was understanding of her problem and sympathetic toward her, no one could keep her baby for her. She was living with a sister at that time; but after the birth of the baby, she would not be able to return there for lack of room.

The social worker discussed possible plans and suggested the possibility of a home (shelter) for unmarried mothers where the girl could live with her baby until she could decide on a permanent plan.

An appointment was arranged with the "shelter" and Miss Long agreed to discuss what was involved in shelter care directly with that agency before reaching her final decision. Later she would also discuss this plan with her family. Miss Long was aware that,

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should she decide against this plan, she might return to the hospital social worker who would be able to make other suggestions.

The foregoing case points up the need of the private patient, as well as the ward patient, to learn of resources in the community. An interview by a trained social worker is often necessary to explore the situation in order to determine which agency in the community will best meet the particular patient's need.

The Case of Mrs. Grand

The following case also involves a private patient. The nurse on obstetrics called to tell the social worker of Mrs. Grand, a 34 year old woman who had been delivered of her first child. Mrs. Grand had paralysis of the right hand for which the doctor believed there was no medical basis. Mrs. Grand seemed to be disturbed and the nurse thought that she might have a problem which she would be willing to discuss with the social worker.

At first Mrs. Grand indicated that she had no place to go with her baby. Mr. Grand, who was a corporal in the army, was home on furlough. Mrs. Grand had followed her husband around from camp to camp and had no furniture or apartment of her own. She was unable to care for a household or her child because of the condition of her arm. The social worker later learned that Mrs. Grand's plan, prior to her delivery, had been to share a bungalow at a beach resort with one of her sisters and to remain there during the summer months, after which time she and her baby would be able to join her husband. Mrs. Grand believed that she could no longer hope to share the bungalow with her sister, since the sister was not well enough to be of assistance.

After discussing the family situation and determining the family's inability to meet the full cost of a housekeeper or practical nurse, the social worker suggested the possibility of obtaining a housekeeper from a family agency. Although Mrs. Grand saw this as the best solution to her problem, she did not want to ask a family agency for help. She believed that she was an independent person and that her sisters and her husband, as well as she would consider the need to ask for help a disgrace.

The social worker spent a great deal of time helping Mrs. Grand to see that seeking assistance with an immediate problem was not an indication of weakness. When Mrs. Grand was able to see that there was strength in knowing when to ask for help, she accepted the advisability of the social worker's seeing Mr. Grand. The eventual plan would be to refer Mrs. Grand to a family agency for help in obtaining a housekeeper.

During this interview, the social worker learned of Mrs. Grand's concern about her illness. Two members of the family had died from heart conditions, one of them having had paralysis of the left side prior to her death. Mrs. Grand was afraid that her paralysis indicated a heart condition and that she, too, might die soon.

She knew that the doctors believed that her paralysis was on a psychological basis, but she was not able to accept this as true, since she felt that basically she was a happy person and that she had no need for such an illness. She thought that having an illness on such a basis meant that she was "crazy." The social worker explained that it did not mean this at all. When Mrs. Grand was able to accept and understand that she was not considered demented, she felt free to tell the social worker of the many family problems she had. Then the social worker suggested that she bring these problems to the attention of the family agency.

When Mr. Grand came to see the social worker she learned that in civilian life he was a lawyer and had some understanding of his wife's problem and was anxious that she get help. The social worker referred the patient and her husband to the family agency and was later advised by the agency that it had sent a housekeeper into the home. Mrs. Grand's arm condition had improved slightly and her doctor believed that she should be entirely cured in one month. If at that time Mrs. Grand were not improved, the family agency would consider having her seen by a psychiatrist, since a psychological basis for her illness then could be established.

This case points up the problems which soldiers' wives had to face during the war and shows how a private patient was able to get help with her problem from the social worker in the hospital and from a social agency in the community.

This patient's physician believed that the improvement Mrs. Grand showed after she returned home was in part due to the fact that she no longer was faced with the problem of how she would manage the care of herself and the baby. Mr. Grand was greatly relieved in knowing that when he returned to camp there would be someone interested in his wife to whom she could turn for help.

The Case of Baby Roberts

The following is a case of a baby on the pediatric service who came to the attention of the social worker by way of a telephone call from the grandmother who stated that the baby was to be discharged from the hospital on this day and begged the social worker to keep the child in the hospital over the week end since her son would then be able to make arrangements for his care.

The woman explained that her son and daughter-in-law loved children but were unable to have any of their own. They had known that it took a long time to get a baby through a recognized adoption agency and therefore had attempted to get a baby privately.

The Roberts family had adopted a child in this manner and had had him with them for eight months when his mother had demanded that they give the child back to her. It had been disturbing for Mr. and Mrs. Roberts to have to do this since they had become attached to the child. The Roberts family then obtained another baby through the same method and had had the baby at home for two months when he developed a twitching. The baby had been brought to the hospital where his condition was diagnosed as a possible epilepsy.

The Roberts' doctor had advised them against keeping the child and Mr. Roberts, the adopting father, was planning to get in touch with the real mother, Miss Jones, to have her take the child back. The worker was able to have the child remain in the hospital and offered her services to the family in working out its problem in the event that Mr. Roberts found he was unable to make satisfactory arrangements.

As was expected, Mr. Roberts was unable to persuade Miss Jones to take the child back. She had given birth to the child out of wedlock and since her family did not know about the incident, she could not at this time take the baby. Miss Jones was going with another man who wanted to marry her, and she did not feel free to tell him about the baby. She was upset about being faced with the problem of the care of the child since she had believed that everything was settled.

Mr. Roberts believed that he definitely could not take the baby home because it would be too upsetting to his wife to care for the child, knowing she would have to give it up eventually. Mr. Roberts was anxious to have the baby discharged from the hospital and to have permanent arrangements made, inasmuch as the baby was on private service and he was meeting the cost of this care. Because of the baby's condition, the social worker could not refer the child to a regular adoption agency, because an adoption agency will not accept a child who is not physically well.

The baby could be considered for placement only through the Department of Mental Hygiene which does not accept children under the age of 6 years. The social worker wrote a detailed letter to the state commissioner of mental hygiene requesting that an exception be made in this case. Because of the crowded condition of the state institutions, the state could not consider taking this child. None of the social agencies in the community could take the responsibility for helping Mr. Roberts or Miss Jones make arrangements for placement of the child, because of the lack of resources in the community.

In an effort to meet this problem, the social worker interviewed Mr. Roberts on several occasions and also interviewed Miss Jones. The worker brought this case to the attention of the hospital administrator who was able to have the child admitted to a city hospital, on the basis of the information the social worker had obtained regarding the family situation and the lack of community resources. Then the social worker referred Miss Jones to an agency where she could get help with her own problem, since she would still be the one responsible for the child's care. Mr. Roberts was referred to an authorized adoption agency where he could apply for a child.

Protection for Parents

The preceding case points up many problems. One can see that adopting parents have no protection when they adopt a baby through private sources. If the Roberts family had obtained this baby from a recognized agency, the agency would have taken the child back when they learned he was sick, and would have arranged for the cost of his care. In fact, the baby would not have been placed with the adopting parents because the agency would have been aware before placement that he was not well.

One can see, too, that the real parent, the unmarried mother, had no protection because the baby was given back to her when she was under the impression that she would no longer have to be concerned about it. If Miss Jones had given her child to a recognized agency rather than to a private family, the agency would have worked out substitute plans more smoothly and the mother would not have had to go through the emotional strain of making additional plans.

The lack of community resources presents a problem to the hospital, the medical social worker and the people involved in the case. Because of the lack of adequate resources in the community, the hospital often has to keep patients who are not in need of medical treatment. This practice means that beds needed for acutely ill patients are not always available.

In some instances, the social worker may have to call upon other hospital personnel, such as the director of the social service department or the hospital administrator, to bring pressure to bear on community agencies in order to have exceptions made regarding admission policies. In reality, this child did not belong in a city hospital, which is set up to meet the needs of acutely ill patients. From a community point of view, in having this child placed in a city hospital, the social worker was robbing Peter to pay Paul. Had there been an agency or institution set up to take care of an epileptic infant, the unmarried mother and the adoptive parents would not have been faced with so difficult a situation.

Many hospital administrators have accepted the rôle they must play in stimulating the establishment of more adequate resources in the community because they are aware of how the lack of community resources affects not only the smooth running of the hospital but also the continuation of medical care for their patients.

To summarize, during 1944, 37 private patients came to me for help. This number may seem like a small proportion when one considers that the social worker on the obstetrics service had approximately 250 patients referred to her during a one year period. Actually, when one considers that the social service department is set up primarily to help the ward or clinic patient, this is a large number. Although the proportion of private patients served by the social service department described is small in relation to the number of private patients in the hospital, the problems raised are a manifestation of the possible needs of the others who did not come to the attention of the social service department.

The cases illustrated prove that people with adequate incomes may still be faced with problems with which they need help, and that social problems come to the doors of the rich as well as of the poor. The problems these patients have presented emphasize the fact that the services of a social service department within a hospital setting cannot be limited to the economically underprivileged patient. If the patient is to be treated as a whole person, he should have the benefits of social study and case work when he has expressed a need for help.

Need Is Equally Great

I have referred primarily to case situations in one division of the medical setting, namely, obstetrics. One would expect that the need for the services of the social worker might be equally great in other divisions. During 1945 there was a total of 174 private patients, including those who were hospitalized, as well as patients seen in doctors' offices, referred to the social service department. I was interested to learn that 141 private patients were referred in 1944, indicating an increase within one year in the recognition by physicians of the need for social service consultation.

Doctors are becoming more and more aware of the social component of illness. They have come to recognize how the emotional problems, social situations and medical conditions are interrelated. In dealing with their ward patients, the doctors have been able to call upon the social worker for evaluation of the patient's social situation and of the meaning of the illness to the particular patient. One wonders, inasmuch as most doctors have found this type of aid so helpful, why the private patient should be deprived of this all inclusive service.

As hospital administrators, doctors and private patients become more aware of the complex social problems that affect the patient and his health, one may look forward to an even greater demand for the social worker's service to the private patient.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

CONTINUING A STUDY BY THE DIVISION OF HOSPITAL FACILITIES

UNITED STATES PUBLIC HEALTH SERVICE

SERVICE DEPARTMENT

DIETARY DEPARTMENT

EFFICIENT KITCHEN DESIGN is a highly specialized subject and employment of a competent kitchen engineer, for preparing detailed plans for this department is desirable.

The dietary department is normally located on the ground floor. To ensure adequate natural ventilation, the kitchen level should be no more than 4 feet below the grade at any point. While an upper or top floor location for the kitchen occasionally has been used in order to eliminate problems of heat, noise and odors, such a location utilizes space that is more desirable for patients' areas.

The ground floor location eliminates undesirable traffic in daily delivery of supplies of meat, vegetables and dairy products. A door to a service court allows deliveries to be made directly into the refrigerator section and saves carting of supplies through corridors and cooking areas.

There should be no traffic through the kitchen to other areas, such as storerooms or laundry. Special attention must be given to the utilities services, ventilation, rat and vermin proofing and general sanitation. Minimum ceiling height should be 12 feet. Floor and walls should be of tile, the latter to a height of at least 6 feet. Mechanical ventilation independent of the general ventilating system is recommended.

Elevators are important in the satisfactory delivery of food to patients' areas and should be located as close as possible to the kitchen. If possible, one elevator should open directly into the serving area so that traffic through basement corridors is eliminated.

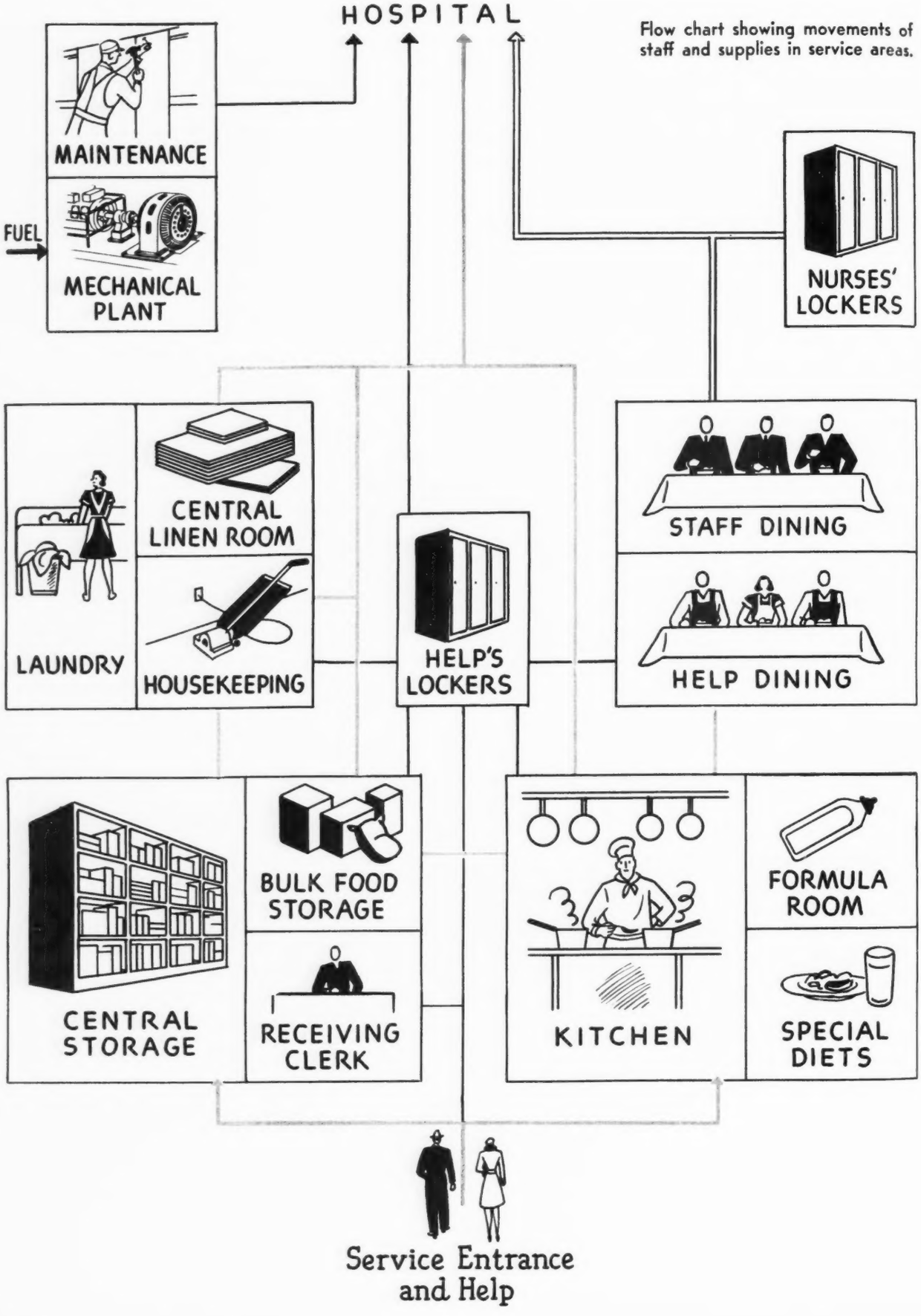
The areas assigned to the dietary department in the accompanying area tables are based on the use of centralized tray service.

There is considerable controversy over the relative efficiency of central tray and bulk food services; each type has both advantages and disadvantages. Inasmuch as food is most important in patient welfare and public good will, serious study must be given to the method to be adopted before plans are drawn.

With central tray service, patients' trays are completely served in the main kitchen under the immediate supervision of the dietitian, who is expected to check each tray for contents and appearance. From this point, they are loaded on dumbwaiters, vertical tray conveyors or tray trucks, either open or insulated, and are transported to the various floors. Soiled dishes are collected and returned to the central dishwashing room.

This system requires fewer, though better trained, employes and there is some saving in initial equipment costs. The most serious complaint is that food becomes unpalatable by the time it reaches the patient. Many authorities state that this difficulty can be overcome by efficient organization.

The bulk service system utilizes an insulated, heated cart somewhat like a steam table. Food is loaded into the cart in bulk and transported to the



Flow chart showing movements of staff and supplies in service areas.

patients' area. In the meantime, trays have been prepared in the floor pantry and, under the best use of this system, a tray truck accompanies the food truck down the nursing corridor. At each room the patient's tray is served from the bulk cart. Soiled dishes are usually handled in the dishwashing room on the floor which requires a dishwasher for each floor or nursing unit.

Advocates of bulk service claim that while preparation and general service of food as a therapeutic measure must be under the immediate direction of a competent dietitian, its immediate service to the patient must be supervised by the nurse in the absence of the dietitian from the floor. Bulk service requires more, but less experienced, personnel to function efficiently, which is an important factor because of the larger turnover in this class of employe. Hot food is said to be practically assured by this method.

In larger hospitals where long distances must be covered, bulk service is almost mandatory. In vertically built large hospitals, central tray service has sometimes been satisfactorily organized.

The main components of the dietary department are food refrigeration and storage, cooking, serving, special diets, dishwashing, dining and (if included) formula preparation. These must be laid out with proper consideration for traffic lines within the kitchen and with related units properly grouped.

A good traffic flow requires that the refrigerators and day storage area be located at the rear of the kitchen so that the food progresses through various stages to the serving area at the front. From the refrigerators the food is taken to the preparation areas where it is cleaned, peeled and cut and then to the cooking areas from which it moves to a steam table in the serving area. The trays, previously set up, are served, loaded on the tray trucks and taken to the elevators for service in the patients' areas.

Dietitian's Office. When a separate office is provided for the dietitian, the preferred location is next to the kitchen. There is some objection to this because of the noise and heat at times, but it does enable the dietitian to supervise the work in the kitchen while otherwise engaged.

Refrigeration. As stated previously, direct delivery of perishables to refrigerators without their going through the food preparation areas is highly desirable. This can be accomplished by providing a door from the service court adjacent to this area. An objection to this practice is raised by some hospital administrators on the grounds that such a door is difficult to control and results in the loss of food supplies. The importance of this point must be compared to the advantages of a delivery door.

Three main walk-in compartments are furnished in the refrigerator, one each for meat, vegetables and fruit, and dairy products. These will vary in area with the size of the hospital and its buying policy but the minimum practical size of each compartment is about 5 by 6 feet. Each should be fitted with open shelving. The meat section should have meat hooks in addition. A separate section with low temperature refrigeration for storage of quick-frozen products is highly desirable. Additional reach-in refrigerators are required for leftovers and salads either as part of the main refrigerator or as units located elsewhere in the kitchen.

Day Storage. Provision of a day storage area in the kitchen is based on the assumption that a central storeroom for the hospital will be maintained and that nonperishable supplies will be requisitioned by the dietitian for the ensuing twenty-four hour period. The area required varies with the size of the hospital but is roughly 1.5 square feet per bed. A frozen food locker may be provided here when a low temperature refrigerator is not practical. Verminproof storage cans, shelving and a locked storage cabinet for replacement supply of dishes will be required. Outside ventilation is necessary.

Main kitchen and bakery. The area assigned includes all space for food preparation (except the special diet kitchen and formula room), pot washing, serving area and tray truck storage space.

The meat and vegetable preparation areas should be in convenient relationship to their respective refrigerators and cooking areas. In larger hospitals, the meat preparation area may be treated as an anteroom to the meat refrigerator. A table, meat block and sink are required. In the vegetable preparation area, equipment consists of preparation table with bins, vegetable peeler and double compartment sink with one drainboard. The peeler should be located at the side of the sink so that vegetables can be dumped directly into the compartment thus eliminating the labor of transferring them by hand.

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
SERVICE DEPARTMENT				
DIETARY FACILITIES				
(designed for central tray service)				
Main kitchen and bakery	1,040	1,190	1,350	1,915
Diet kitchen and dietitian's office	150	230	260	350
Formula room	—	255	255	255
Dishwashing and truck washing	180	200	200	255
Refrigeration:				
Meat	30	30	30	35
Dairy products	30	30	30	30
Fruit and vegetable	30	30	45	75
Garbage and can washing	60	60	100	120
Day storage	105	105	150	200
Dining space, *including serving space*				
Staff supervisory, employes and nurses, *(two sittings)*	310	540	810	1,080
Employes *(two sittings)*	210	400	540	720
Total	**2,145**	**3,070**	**3,770**	**5,035**
HOUSEKEEPING FACILITIES	1,365	1,480	1,800	1,970
Central linen room, sewing room and housekeeper's office	300	390	400	435
Soiled linen	130	195	225	260
Laundry	935	1,220	1,700	2,020
Total	**1,365**	**1,805**	**2,325**	**2,715**
MECHANICAL FACILITIES				
(No fuel storage space included)				
Boiler and pump room	900	1,200	1,400	1,500
Engineer's office	—	80	100	120
Maintenance shop(s)	130	200	300	350
Total	**1,030**	**1,480**	**1,800**	**1,970**
EMPLOYES FACILITIES				
Nurses locker room (a)	330	540	755	900
(Including lockers, toilets, showers and restroom)	*(24 L.) b (1 T.) (1 Sh.)*	*(48 L.) (2 T.) (2 Sh.)*	*(72 L.) (3 T.) (3 Sh.)*	*(96 L.) (4 T.) (4 Sh.)*
Male help's locker room *(including lockers, toilets, shower and rest space)*	180 *(13 L.) (1 T.) (1 Sh.)*	270 *(25 L.) (1 T. 1 U.) (2 Sh.)*	370 *(38 L.) (2 T. 1 U.) (3 Sh.)*	410 *(50 L.) (3 T. 1 U.) (4 Sh.)*
Female help's locker room *(including lockers, toilets, shower and restroom)*	255 *(13 L.) (1 T.) (1 Sh.)*	405 *(25 L.) (2 T.) (2 Sh.)*	470 *(38 L.) (3 T.) (3 Sh.)*	585 *(50 L.) (4 T.) (4 Sh.)*
Total	**765**	**1,215**	**1,595**	**1,895**
STORAGE				
Record	175	240	330	390
Central stores (c)	1,000	2,000	3,000	4,000
Total	**1,175**	**2,240**	**3,330**	**4,390**

(a) Includes provision for special nurses.
(b) L: Lockers; T: toilets; Sh: showers; U: urinals.
(c) Minimum. Based on 20 square feet per bed. Many authorities recommend storage areas up to 40 square feet per bed.

The main cooking section consists of ranges, fryers, broilers, ovens, steam kettles and steamers. This equipment is best placed in a central location convenient to the serving area and away from walls where the cleaning problem is more difficult. A recommended arrangement is to place the ranges, fryers and broilers back to back with the kettles and steamers. This is a space saving device which at the same time separates the meat cooking and vegetable cooking functions. A cook's table and convenient water supply should be provided for each side. A hood for mechanical ventilation will be required over the cooking equipment.

A separate bake shop is usually required in larger hospitals, but in most smaller institutions the volume of baking does not justify such provision. The oven can be located with the other cooking equipment where it will also be used for roasting and baking of meats. Baker's table, refrigerator and pan rack are required. The baker requires the use of a mixing machine for preparation of dough and icing. As the mixing machine is also used for vegetables, it should be convenient to both departments.

The pot washing area should be located off the main traffic lines but near the ranges from which most of its work comes. Since this is a noisy, steamy area it may be enclosed in a separate room in larger hospitals where space permits. A two or three compartment, deep sink with two drainboards and pot racks will be required. Space for cart washing may be provided either here or in the dishwashing room.

The serving area includes space for salad preparation, steam table and truck parking. Salad preparation in smaller hospitals will require only a large table with a refrigerated compartment below. Additional refrigerator space and work table will be necessary for larger hospitals. The mixing machine in the cooking area may be used for the preparation of salad dressings. Water supply should be conveniently located.

Adjacent to the serving area are placed the ice cream cabinet, coffee urns, egg boilers and tray setup table. The tray setup table should be located next to the dishwashing room with an opening to the dishwashing machine; this will be discussed later.

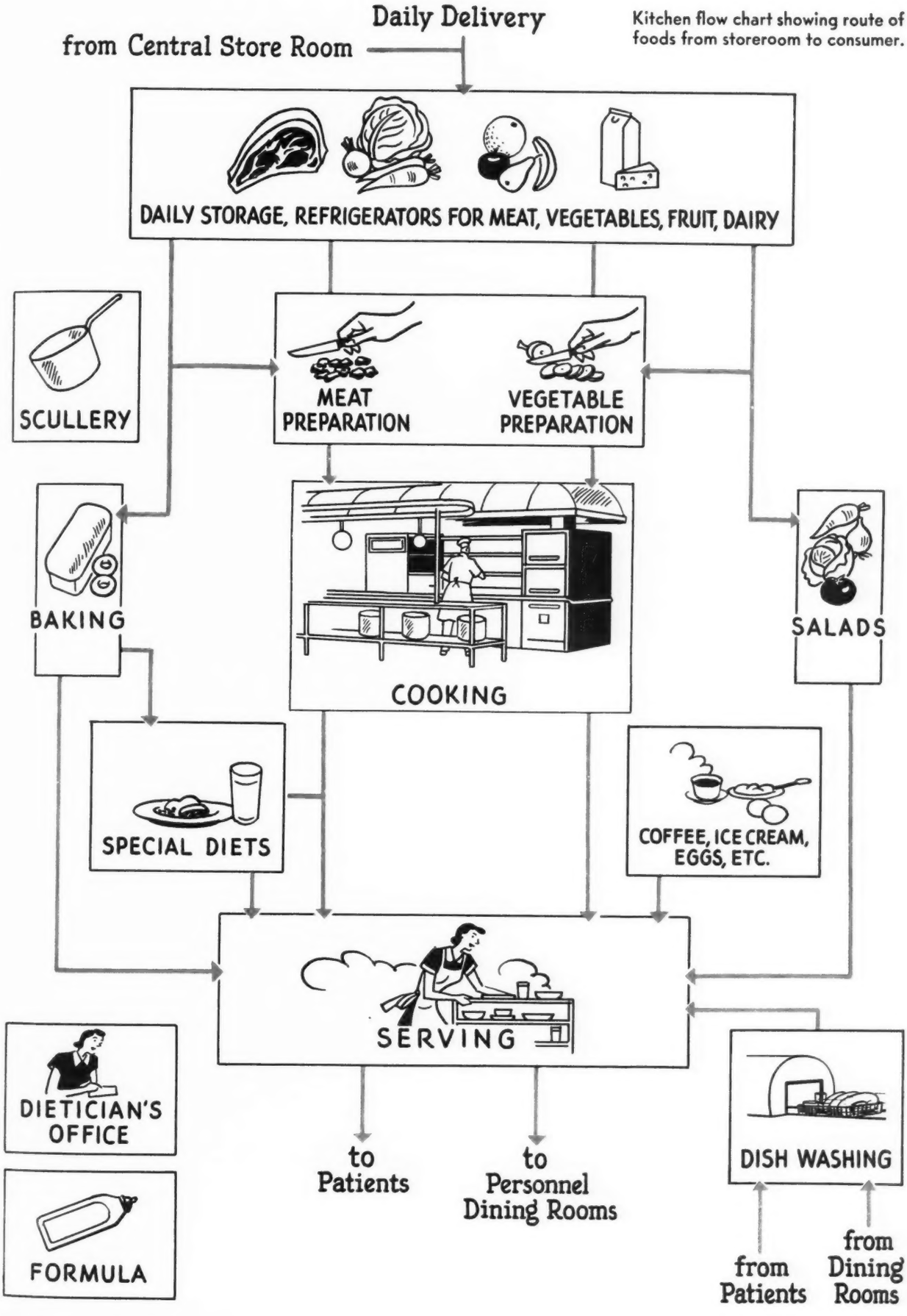
Special diet kitchen. The special diet kitchen should be located off the main kitchen and may be separated from it by a low partition. In small hospitals, the dietitian's office may be included in this area. Where possible, dumbwaiter connection with floor pantries on the nursing floors is desirable.

Minor cooking equipment is all that will be required since bulk cooking will be done in the main kitchen and only minor modifications, in most cases, will be performed in the diet kitchen. Equipment will consist of steam table, counter, range, sink, refrigerator, tray rack and bulletin board. Where the dietitian's office is included, a desk, filing facilities, book shelves and a long table or counter for arranging diet cards will also be required. A somewhat larger area is required in teaching institutions.

Formula room. Because of differences of opinion as to the location of the formula room it is not discussed here but was covered in the nursery section.

Dining space. The dining space may be provided on a basis of two sittings for the personnel served. It should not be located in the basement unless sufficient natural light and air are available.

Either cafeteria or table service can be installed. Cafeteria service requires the usual counter with tray, napkin and silver space, steam table with dishwarming compartment, cold pan, shelves, coffee urn, ice cream dispenser, toaster, sink in counter and water cooler. Table service in the small hospital may be given from the kitchen. Larger hospitals will require a serving room with equipment similar to that noted for cafeteria service. Clean, attractive dining areas for all employes are essential.



Kitchen flow chart showing route of foods from storeroom to consumer.

A bulletin board, clock, radio outlet and house telephone should be provided in each dining room. The areas can be so arranged that one or more of them can be used for staff conferences and other meetings if other space is not provided. When two or more dining rooms adjoin, folding doors can be used that will permit the rooms to be combined for large meetings.

DISHWASHING ROOM. The dishwashing room should be located at the entrance to the kitchen adjoining the tray setup area and on an exterior wall for natural ventilation.

Every precaution should be taken to prevent handling soiled and clean dishes by the same person. This has been accomplished by having the dishwashing machine set at an opening in the wall so that the clean dishes emerge from the machine at the tray setup area in the adjacent room.

The dishwashing room is perhaps the noisiest unit in the dietary department and therefore should be located where the noise will not be audible in patients' and dining room areas. The room finish should be easily washable, moistureproof and acoustically treated.

The room should be equipped with slide counters for soiled dishes, leading directly to the dishwasher, with a section for dish scraping and a garbage can below. A double compartment sink for soaking and for emergency washing is also required.

A suggested improvement over the standard scraping block has been made in the form of a deep sink in the counter. Into the sink, which must be narrow enough to permit dish racks to slide over it, is placed a wire basket which retains scrapings and any silverware accidentally dropped into it but which permits liquids to drain out. Above the sink is a short rubber hose (to prevent breakage of dishes) which is attached to a water outlet controlled by a foot pedal leaving both hands free to brush or scrape dishes. This treatment reduces the bulk of garbage, which usually consists of about 50 per cent liquids, and eliminates loss of silverware. Special machines have been developed for this purpose.

Space is usually allowed in the dishwashing room for truck washing. In larger hospitals, a separate truck washing area may be provided. For easy cleaning and flushing, the dishwashing room should have a floor drain.

GARBAGE STORAGE AND CAN WASHING ROOM. A refrigerated room for garbage storage should be located at the delivery door for easy handling and, when possible, close to the dishwashing room, which is the greatest source of garbage. An adjacent room for can washing is necessary. It should be provided with a floor drain and hot water and steam outlets for sterilizing cans.

REFUSE DISPOSAL. Total refuse from a hospital, exclusive of ashes, may amount to several pounds per day from each individual. Of this, food wastes will constitute from ½ to ¾ pound.

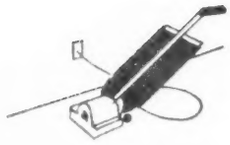
Disposal has more health implications than has the disposal of such material from an ordinary building or community. In addition to the usual garbage and refuse will be included such things as infected dressings, discarded surgical specimens, food scraps from patients' dishes, which should be considered infected, and similar material. All classes of refuse must be disposed of by incineration with the exception of the food scraps which may be disposed of in the sewer if a garbage grinding device is provided, as will be discussed later. In some cases it may be practical to use the central heating plant for incineration. On the other hand, it is usually desirable to provide an incinerator for the disposal of all garbage and trash.

If a separate incinerator is provided to burn all refuse, including organic wastes, it will probably be necessary to make provision for forced draft and auxiliary fuel as the incinerator will not be in service at all times but will be started each day. All combustion gases should be passed through a furnace temperature of 1400° F. average and 1250° F. minimum to prevent odor and smoke nuisance. As the design of incinerators conforming to these specifications is a specialized field, it is suggested that the unit be purchased from a reliable manufacturer.

If separate incineration is to be provided for readily combustible materials only, a suitable incinerator can be readily built. "Military Preventive Medicine" by George C. Dunham (Military Service Publishing Company) is suggested as a reference book.

The disposal of garbage through the sewerage system, as is done when a garbage grinding device is used, is a satisfactory method of disposal. If this method is used and if the hospital has its own sewage treatment plant, this additional load on the plant must be considered in its design.

TOILET FACILITIES. Convenient toilet facilities should be available for kitchen employes. However, they should not be within the kitchen area. Handwashing facilities should be freely provided within the food preparation area.



HOUSEKEEPING FACILITIES

HOUSEKEEPER'S OFFICE AND STORES. The housekeeper's office may be located in the basement, preferably adjacent to the central linen room. Space for a desk with house telephone and files for the housekeeping records should be provided.

Shelving is needed for housekeeping supplies, which may be dispensed through a wicket or over a counter. Card files and locked racks for the key control system are located in this office. In some cases it may be best to keep the key control system in the chief engineer's office.

CENTRAL LINEN ROOM. Central linen room facilities are designed to furnish all linen supplies for the hospital. The small linen closets throughout the hospital will be sufficiently large to hold only one set of linen for the area in which they are located. Provision is necessary in the central linen room for blanket storage and a sorting table.

Either in this room in small hospitals, or in an adjoining room in larger hospitals, space and equipment are needed for mending and sewing, as well as for marking new linens. Shelving, table space, sewing machines, house telephone and a marking machine are to be provided. Space for linen trucks and their loading will be required. When the laundry is in the hospital proper, the central linen room should be located adjacent to the "clean" end of the laundry and with convenient access to the elevators.

When the laundry is located in an outbuilding or when there is no laundry in the institution, the central linen room should be convenient to the tunnel or other entrance through which clean linen is delivered to the hospital.

SOILED LINEN. The soiled linen area is designed for a weighing, sorting and checking room for all soiled laundry from the hospital (except contaminated linen) and for sorting, checking and marking personal linen of employes living in the institution. Equipment will be limited to a marking machine, scales and sorting bins and tables. The soiled linen room should be adjacent to the "soiled" end of the laundry, if there is a laundry in the hospital. If there is not a laundry in the institution, this area may be restricted to checking outgoing laundry and the sterilization of infected linen.

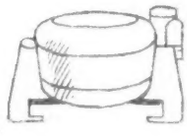
When there is no laundry in the institution, the soiled linen room should be convenient to the service entrance. A soiled linen chute (24 inches is the recommended diameter) may be installed with an opening on each floor. In large hospitals, two chutes may be required. The chute should be open at the bottom and should lead into a small closed room. A flushing device for hot water or steam is provided at the top of the laundry chute and a drain is placed at the bottom.

As previously stated, use of linen chutes is controversial and soiled linen may be transported in hampers with casters which are manufactured for that purpose.

In large hospitals, a bulk sterilizer (mattress type) may be installed, although exposure on sun racks is stated to be sufficient ordinarily.

LAUNDRY. It is accepted as good administrative practice to have a laundry in any hospital of 40 or more beds. Whether or not a laundry is included, however, will depend on local conditions and on administrative policy. If one is supplied, the services of a competent laundry engineer should be utilized in designing and equipping it.

In small hospitals, the laundry may be located in the basement with easy access to elevators, but isolated from the patients' areas because the noise, odors and steam are objectionable. Ceiling height in the laundry should not be less than 12 feet, and adequate lighting and mechanical ventilation will be required. An adequate supply of soft water, hot water at not less than 180° F. and steam at a pressure of not less than 100 pounds is essential.

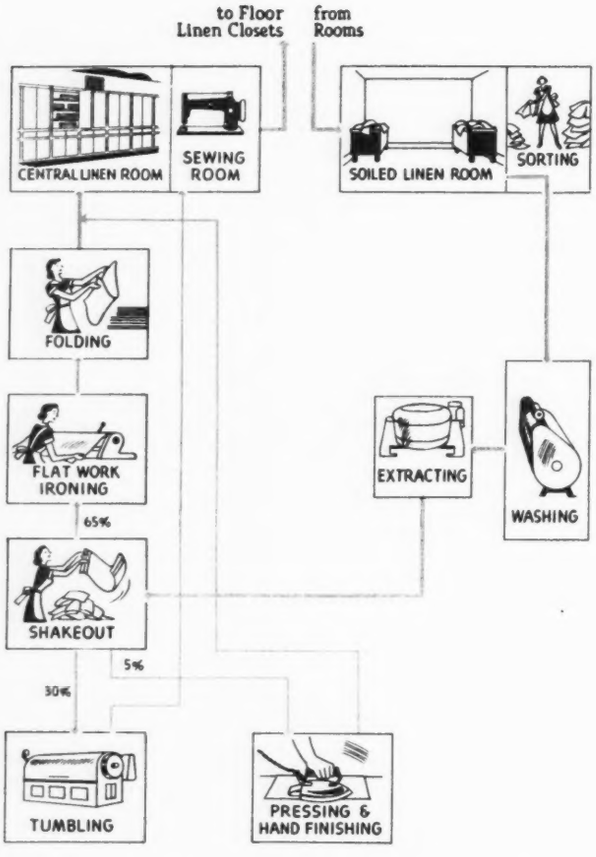


Routing is important in the laundry area and will proceed from the soiled linen (sorting) room through (1) washing wheels, (2) extractors, (3) shake table, (4) tumbler or flatwork ironer, presses or hand finishing to (5) the central linen room.

At the washing area a platform scale for weighing laundry should be provided.

It is advisable to provide one large and one small washing machine. The machines are placed over a trench for discharge of used water. The floor for 5 feet in front of the washers should be slightly pitched to the trench. The soap tank and starch cooker should be located convenient to this area.

Opposite the washers should be placed the extractors which remove most of the excess moisture in the wet laundry before it goes on to other processes. The shakeout table is used to separate the laundry into various categories as it comes from the extractors. Therefore, it should be located centrally so that it can easily be reached from the extractors whence laundry can be transferred to the other equipment.



Flow chart of traffic within laundry department.

About 22 per cent of the laundry goes to the tumblers where it is dried by hot air. About 8 per cent will go to the presses and ironing boards. The greatest amount, or about 70 per cent, will go to the flatwork ironer where the heat of the steam chamber dries it while it is being ironed. Because of the large percentage of laundry handled by the ironer, it should be located near the central linen room to facilitate transportation of finished laundry. A hood should be provided over the ironer to carry off excess heat and vapor.

A pair of laundry trays is usually provided for soaking stains out of linens. A large closet for storage of supplies will be required. Telephone, clock, bulletin board and fire extinguisher will be needed in the laundry area.

When locker rooms are remotely located from the laundry, toilet facilties for laundry employes should be provided in the area.

EMPLOYES' FACILITIES

THE TREND IN LABOR and administrative relations is toward the provision of better facilities than has been the practice in the past.

Employe lockers and restrooms should be convenient to the employe entrance. It is considered desirable practice to permit neither professional nor nonprofessional employes to go through the building in street clothes; therefore, locker rooms are so located as to obviate, as far as possible, the necessity for traversing corridors between the entrance used and the locker rooms. Some hospitals desire separate facilities for volunteer workers.

NURSES' LOCKER ROOM. In designating the size of the nurses' locker and rest room, it is assumed that there will be no nurses' home on the hospital grounds. If graduate nurses are housed, the locker room may be smaller than indicated. A separate locker room for special nurses is usually not required, the same room being used for both special and staff nurses. This area is equipped with individual lockers, a built-in counter for a dressing table of sufficient length to accommodate several persons and with mirrors above, stools, bulletin board, two chairs, end tables, full length mirror and one Hollywood bed; adjacent are shower, toilet and lavatories.

LOCKER ROOM FOR MALE EMPLOYES. The sizes of the locker rooms for male and female employes are based on the assumption that approximately equal space will be required. However, the ratio of male and female employes may vary and size must be adjusted accordingly. The locker room for male employes is furnished with a bulletin board, toilets, lavatories, shelf and mirror, shower baths, chairs and table and individual lockers. Some objection has been expressed to installation of urinals.

LOCKER ROOM FOR FEMALE EMPLOYES. Equipped the same as nurses' locker room.

STORAGE FACILITIES

CENTRAL STORAGE. Design for storage must be in accordance with local purchasing practices and needs. For these reasons it is advisable for the purchasing agent and stock clerk to be consulted when the storage area is being planned.

The area shown does not include space for kitchen day stores, refrigerated food storage or fuel storage. It does include space for bulk pharmacy stores, facilities for the storage of special beds, large orthopedic equipment, extra equipment and for all supplies and replacements to be issued for use throughout the institution.

In the average hospital, minimum requirements for central storage are 20 square feet per bed. However, in small hospitals, experience has shown that this is inadequate to provide for sufficient storage space and for desirable departmentalization. Also, less than this amount does not allow for the 30 per cent expansion which is considered ideal in case of need.

If the hospital is situated away from central markets, the space must be sufficiently large to permit storage of supplies purchased in quantity.

In planning a central storeroom, the pharmacy storeroom, furniture room and anesthetics storeroom should be independent of the main storage area, although immediately adjacent.

The pharmacy stores are usually handled by the pharmacist rather than by the general storekeeper. When this room is kept separate, pharmacy stores are available without allowing access to the other storage areas.

The furniture room must be available at any hour as a bed or fresh mattress may be needed in an emergency when the storekeeper is off duty. This room should have double doors because of the size of the items stored in it. The use of mattress racks and bins for springs and bed ends will make for neatness and orderliness.

The anesthetics storeroom is kept separate and is located at the entrance for availability in case of fire and for easy access in handling heavy oxygen tanks. Besides the anesthetic gases, bulk alcohol and oxygen will be stored here. It must have outside ventilation and be of fireproof construction, complying with local codes.

The delivery and employes' entrances are usually combined and should lead off a covered loading platform into a spacious vestibule or receiving corridor. The vestibule helps keep down heating bills in winter and provides space for a countersunk scale for checking weight of goods received, laundry sent out and other items.

The receiving corridor should be wide enough to allow uncrating and unpacking some of the goods before they are taken into the storeroom. Ten feet is suggested as a minimum width. Occasionally a delivery will have to remain in the corridor until it can be disposed of properly and there must be room enough for other traffic in the meantime.

The stores office (or issuing and receiving room) is placed off the receiving corridor. It should connect with the main storage area so that the storekeeper can enter the main storeroom without going into the corridor. The office should have a counter with a window opening into the corridor for dispensing goods to employes and checking entries and departures from the building. Time clock, employes' card rack and bulletin board may be located on the wall opposite in the corridor.

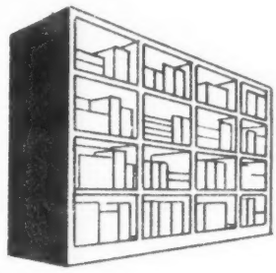
In the office, there should be a desk, chair, file cabinets, house telephone, clock and locked cabinets.

The counter in the office is open below so that dollies and conveyors can be stored when not in use. Special packages can also be stored there. The locked cabinets will be for the storage of instruments and other relatively valuable items which should be kept under lock and key.

The main entrance to the storeroom will be kept locked and no one but the storeroom staff and, occasionally, delivery men will be expected to enter the storage space. Requisitions will be turned in at the office window, and deliveries will be made up in the storage space and sent to the floors.

A makeup counter directly outside the office and near the hall doors allows for the easy collection of items from various sections of the area. At one end of the counter a roll of rubber sheeting may be set up for easy dispensing.

A fairly large space should be left at the front of the general storage area for bulky items.



A platform should be provided along the front wall set 4 inches above the floor so that the floor can be cleaned easily without damage to the containers or without having to move them. Heavy drums of oil need not be trucked far under this arrangement. Furthermore, they are readily available for distribution of oil in small containers as needed.

The general storage space may be made up of a series of interchangeable shelving units which can be neatly set in rows, back to back, between windows which allow for light and ventilation. The bottom shelf should be 6 inches above the floor to protect goods from moisture and from damage during cleaning. The use of adjustable shelving provides for storage of various sized items without wasting storage space.

A number of dividers and bin fronts should also be provided so that the shelving can be adjusted to smaller units to take items of different kinds and sizes. A practical type of unit has the lower shelving wider than the upper, thus providing a shelf on which items can be placed while an order is made up. The space between the rows of shelving should be wide enough for the passage of a conveyer of some type for the distribution and collection of goods.

Rubber goods deserves a special cabinet of its own where it can be watched for deterioration. Excessive heat and humidity are harmful. The shelving in this cabinet should begin at a height of about 48 inches above the base so that rolls of rubber sheeting can be stored on and in the lower section.

Food stores are segregated in a separate enclosed area in order to keep vermin out and to aid in keeping the area clean. Three types of storage facilities should be provided. Adjustable shelving is arranged along the walls for storage of small items and broken lots. Platforms for bags of sugar, flour and the like should be as near to the door as possible.

The platform should be raised from 4 to 6 inches from the floor and so constructed that it will be possible to clean underneath it. The flooring of the platforms should be laid with 1 inch open spaces. Corners that cannot be easily reached for cleaning should be avoided as they make excellent breeding places for mice, roaches and other vermin. The entire building, but particularly food storage areas, should be constructed so as to be ratproof. A publication of the United States Public Health Service, "The Rat and Ratproof Construction of Buildings," may be consulted on this feature.

Toilet facilities at or near the delivery entrance for use by grounds workers and truck drivers are a convenience.

Record storage. Space is required for filing (or storage) of inactive medical records, possibly in the basement immediately beneath the medical record library and connected with it by a spiral staircase, but in any event easily accessible from the main record room. If this space is not in the basement, the weight of heavy files must be considered in designing the floor construction. The space provided should be free from dust, moisture and overhead piping. In lieu of standard files, library stacks of steel or wood have been recommended, with 24 inch divisions wherein the files are placed on edge. The increasing practice of microfilming inactive files and records will alter these space requirements considerably.

Film storage. Provisions for storage of films should meet requirements of local fire ordinances and the National Board of Fire Underwriters. Present regulations exclude quantity storage of nitrocellulose film inside hospital buildings.

Patients' clothing storage. If no locker space is furnished in the rooms for patients' clothing and other effects, a storage room, fitted for proper care of these articles and so located as to be accessible to nursing personnel, will be necessary in this area.

MECHANICAL FACILITIES

Boiler room. It is necessary that competent engineers be employed in designing the boiler plant. Consideration must be given to the heating function, furnishing of steam for sterilizing, laundry, cooking and heating domestic hot water. The location of the boiler room must be in accordance with local fire ordinances. Some states do not permit installation of high pressure boilers within a hospital. When they are permitted, the room may be located in the basement, preferably at the end of a wing, with all precautions taken to assure safety of patients and personnel.

Fuel storage. Space for storage of fuel is not included in the area tables because it will vary with the type used. If coal is chosen, space should be provided for its receipt in carload lots, and it should be fed by gravity to the boiler room. Tanks for storage of oil are best located under ground to permit convenient filling from fuel trucks. Provisions for weighing or measuring fuel deliveries are desirable.

Engineer's office. The engineer's office may be located on a balcony level at one end of the boiler room but it must be protected from heat, dust and dirt. Necessary gauges and other regulatory devices are located at this point.

Maintenance shop. The maintenance shop should be convenient to the boiler room inasmuch as the same persons are usually on duty in both areas. In small hospitals, a single shop equipped for general repair work will probably be all that is required. In larger hospitals, this may be extended to include a machine shop, carpenter shop, electrical shop and paint shop. Storage space for minor mechanical supplies must be provided in or adjacent to the shop. A locker room is desirable, and in even the smallest hospital, a toilet and lavatory are required.

Groundskeeper's tool room. Landscaping and garden work are important factors in the administration of most hospitals. Some provision should be made in every hospital for a small work space with storage for tools and equipment. Such an area should be readily accessible from outside.

Garage. Some institutions may require garage facilities for ambulances, trucks and private cars. When the policy of the hospital is to maintain twenty-four hour ambulance service, additional facilities should be furnished for an ambulance drivers' lounge room and, perhaps, sleeping quarters. These facilities are best located in a building separated from the hospital proper.

CANTEEN

It is highly desirable to have a space set aside for furnishing minor items for patients and employes. This may be in the nature of a gift or service shop to supply newspapers, magazines, toilet articles, tobacco, cold drinks and confections by sales service or it may be limited to vending machines.

The Taft-Hartley Bill *and Hospital Administration*

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IN ONE particular the new Labor Management Relations Act, 1947 (Taft-Hartley Bill) leaves no question. Hospitals operating on a nonprofit basis are excluded from the benefits and liabilities of the act. This, in effect, forces a division in any consideration of the new law and hospital administration.

Being excluded specifically from the benefits and burdens of the law may be a relief to many administrators. However, there are certain questions of procedure which make it necessary for those charged with policy determination and administration to be cognizant of the significant features of the act. In general, it may be said that "inside" or "outside" of the provisions the new attitudes created by the bill will have a decided effect upon personnel procedures, bargaining technics and similar problems.

Hospitals have been relatively free from the strike technic of attack because of the general policy of the N.L.R.B. to keep "hands off" as far as requiring union elections in hospitals and institutions.

There Is Potential Danger

The law does give certain new strength to management but it is a strength encumbered by potential danger. Even the keenest advocates of the law are aware of the possible misuse of such legislation by those who would seek revenge on labor for some of its alleged past mistakes. Should such an attitude and misuse develop, not only will any value inherent in the law be lost but immeasurable harm will be done to the whole industrial relations program for years to come. One cannot but hope that management will take a long range view of the problems, will walk carefully and will use the opportunities to build and not destroy.

"The term employer shall not include any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." Sec 2 (2)

Much of the success of the administration of the act will depend upon the individual selected as general counsel. This new position was created to satisfy a demand in the House of Representatives that the judicial and administrative functions of the N.L.R.B. be separated.

"There shall be a General Counsel of the Board who shall be appointed by the President, by and with the advice and consent of the Senate. He shall have final authority, on behalf of the Board, in respect to the investigation of charges and issuance of complaints under section 10 and in respect of the prosecution of such complaints before the Board."

For hospitals not in the nonprofit group the following facts will have significance.

1. The closed shop is eliminated. The law states that: *"It shall be an unfair labor practice for an employer by discrimination in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage membership in any labor organization." Sec 8 (a)*

Even if an employer voluntarily enters into a closed shop argreement and refuses to hire a worker because of nonunion status, the N.L.R.B. can order the employer to hire him. There is some limitation in the effectiveness of this clause in the fact that the board will not act unless a charge of unfair labor practices is filed, and then only on violations occurring less than six months before the charge was filed.

2. The union shop may remain.[1] Employes and unions may agree to a union shop if: (a) the union is the duly authorized or certified representative of the employes in the appropriate bargaining unit or (b) the employes have in an N.L.R.B. conducted election by majority vote authorized the union to sign a union shop agreement.[2]

No union contract now in existence need be changed until its renewal or expiration date. Contracts for one year or less may be entered into during the sixty day waiting period before the effective date of the law.

Some existing union security clauses will be outlawed in new contracts. Illustrative of these are clauses requiring: (a) the closed shop; (b) the preferential shop (union members get first preference in employment); (c) union hiring hall (employer hires only through union hiring hall); (d) union referral (employer agrees to notify union of job vacancies).

3. Foremen and other supervisors are not considered "employes" under the N.L.R.A. While the specification

[1] A union shop is one in which the employe must become a member of the union within a certain number of days after hiring or after the effectiveness of the contract.

[2] The board will not conduct an election unless the union's petition shows that 30 per cent of the employes in the appropriate unit want a union shop. Employes may present a similar petition asking for an election to eliminate the union shop. Until the expiration of present contracts it takes a majority of the bargaining unit to invoke a closed shop.

at first seems to offer an advantage to management there are other possibilities which need careful weighing.

If the foremen are not entitled to the privileges of union organizations under the N.L.R.A. neither are they subject to the restrictions. It may be concluded that they may (1) join their own union; (2) strike without the restrictions of the new prestrike formula; (3) be exempt from government interference provided for when a "strike imperils national health and safety"; (4) be exempt from damage suits resulting from unlawful boycotts or jurisdictional strikes; (5) be left in the "neither fish nor fowl" category by the exclusion of foremen and supervisors from the benefits of the law.

This situation places upon management renewed responsibility for the development of foremen as representatives and part of administration and management. One cannot help wondering to what extent first line supervisors really share in the management picture. Hospitals and industry alike may well find it advantageous to keep supervisors informed on policies and administrative plans.

4. Special exemption from inclusion on the bargaining unit is provided for professional employes.

"The Board shall decide in each case whether the unit appropriate for collective bargaining shall be the employer unit, craft unit, plant unit or subdivision thereof. Provided, that the Board shall not decide that any unit is appropriate for such purposes if such unit includes both professional employes and employes who are not professional, unless a majority of such professional employes vote for inclusion in such a unit."

The foregoing statement offers protection for hospitals against pressures from the plant-wide type of union like that of most C.I.O. setups.

5. Unions as well as employers can be held responsible for unfair labor practices.

6. The N.L.R.B. will not issue a complaint on a violation which occurred more than six months previous to the filing of the charge.

7. Failure to bargain collectively becomes an unfair labor practice for either union or management. The new law defines collective bargaining as follows:

". . . to bargain collectively is the performance of the employer and the representative of the employes to meet at reasonable times and confer in good faith with respect to wages, hours and other terms and conditions of employment, or the negotiation of an agreement, or any question arising thereunder . . . but such obligation does not compel either party to agree to a proposal or require the making of a concession."

8. Employers are guaranteed the right to free speech on union organizations as long as the statements do not threaten or force or promise benefit.

9. A compulsory sixty day "cooling off" period is provided for.

10. Jurisdictional strikes are eliminated.

For the nonprofit hospital it is far from wise to say, "We know where we stand. No union pressure can hurt us." Even though under the law there is no longer a closed shop there are many trades, especially in the larger cities, where the only applicants available are union men who will require union conditions before they accept the position open. Good union relations will still be essential.

The specific exemption of the hospital from the law may have a dampening effect upon the efforts currently being made to organize nurses, laboratory workers and other hospital employes. The keynote for hospital administrators in these coming months will be to do all possible to build the highest type of employer-employe relations based upon recognized procedures which will bring the sense of security, standard wages and employe benefits that have long since been developed in industry to hospital employes at all levels. These are fundamental causes for unionization.

In its weekly bulletin for July 1, 1947, the National Association of Personnel Directors called attention to the problems in the following paragraph:

"It is particularly important that all management representatives be familiarized with the attitude of the employer with respect to the law, and employe and labor relations under the law. It is suggested that such policies be shaped in the direction of dispelling any suspicion which employes may have that employers plan to take unfair advantage of them in such a manner as the law may permit."

VOLUNTEER ACTIVITIES

Women Serve in Eire, Too

Eire isn't so different from the U. S. A. when it comes to women's activities in behalf of hospitals. There is Teach Ultain in Dublin, an institution for children under 2 years old who have noncommunicable diseases. It has a nursing committee, an amusements committee, a working party (sewing group that meets on Wednesday afternoon) and, of course, women board members.

Except for the last two items, the Christmas donations for the nurses might be those of any American hospital: magazines, chocolates, baskets of fruits, cigarets, "tins of biscuits" and champagne cider. The little patients get scrapbooks, toys, games and clothing.

At other seasons the hospital gets bulbs for the garden, perhaps a plum tree, medicine bottles, jams and jellies, books, jigsaw puzzles, old linen and woolens, soap and butter. A raffle brings a wireless set for the nurses' home and some "sitting room" furniture.

Twenty-seven years ago Madeline ffrench Mullen, representing Teach Ultain, made a trip to the United States. Friends made then continue to send gifts to this children's hospital in Dublin. The same year a friend of the hospital compiled "The Book of St. Ultan" (St. Ultan is the patron saint of the hospital) and it is still being sold for the benefit of the institution; the book contains poems, drawings and pictures by AE and lesser lights, with notes on St. Ultan.

The American Red Cross, through the Irish Red Cross, has sent the hospital large quantities of drugs, soap and rubber sheeting.

Among items of equipment at Teach Ultain that the children enjoy are the buttoning and lacing frames. The children love to button and lace and it isn't long until they are applying their new knowledge to their own clothing, a great time saver for the nurses.

The Economic Basis of Hospital Charges

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THE establishment of charges for hospital services differs from the pricing procedure of a commercial enterprise. In the long run the total receipts of both a hospital and a business must equal the total capital expenditures and current expenditures, but the similarity ends there.

A business enterprise is primarily responsible to its owners, who expect a return on, and of, their loans or investments. Customers are sought who, as a group, will pay enough money to cover all costs plus a margin of profit for the investors.

A hospital has no owners, in the commercial sense of the term. It is constructed by people who gain no profit from its activities. It does not limit its customers to those able to pay the costs of the services they receive.

How should a hospital go about determining the prices it will charge for its services to patients? This article will suggest the objectives to be sought in establishing hospital charges and will discuss ways in which various pricing policies contribute to these ends.

Have Four Objectives

Prices for hospital services should be established to achieve four main objectives: (a) recovery of the total costs from those who benefit from the hospital service, directly and indirectly; (b) continuance of a high quality of service; (c) appropriate balance of necessary service for the majority of patients; (d) maximum use of personnel and facilities.

The price of hospital care may be based upon (a) the cost incurred by the institution; (b) the value placed upon the service by the patient or his sponsors. Historically the principle of value has transcended that of cost in determining hospital rates. Charges have been set at levels which patients are willing to pay (or promise to pay), rather than the costs that are incurred in providing the service.

Hospitals should give greater recognition to the costs incurred in providing service, regardless of who pays the bill. Ultimately, of course, a hospital must be paid from some source for the full costs of the services rendered during a period of time. A complete classification of services in terms of their costs should appear in the records and reports of each institution.

In determining the cost of hospital service, several facts demand consideration. First, a hospital is an institution with certain "readiness-to-serve" costs which are largely independent of the number of patients admitted for the various types of service. These include such administrative, housekeeping and professional expenses as salaries of nursing supervisors and available staff, heat, light, power, and maintenance of plant and scientific equipment in condition to accept and serve patients.

Hospital activity is characterized by "joint" costs. There are simultaneous and inseparable expenses in the production of related services, such as board and room care, laboratories, operating rooms and outpatient clinics. If any one of these services is undertaken or discontinued it affects the costs and management of several others.

Questions such as the following arise: Shall board and room care be considered as the "main product" of the hospital? Shall each service be apportioned its share of the readiness-to-serve costs as well as those directly traceable to the amount of service performed? Shall the outpatient department be regarded as a "by product"? What shall be the "unit" of service for which cost is determined? Shall it be a laboratory test, a pharmaceutical prescription, an x-ray film, the occasion of using an operating room, three meals and the use of a bed for a day?

In my opinion, detailed cost information concerning the various "units" of special services are not significant for establishing charges to patients. Knowledge of the costs of entire revenue-producing services (board and room, operating rooms, x-ray) is important when planning the expansion or contraction of a department. But such cost calculations should be made *before* a decision is made to develop or restrict such services.

Patient Has Little Choice

From the standpoint of the patient, hospital service is a single experience. Few of the services are performed merely because he wants them. He is interestd in the amount, not the composition, of his hospital bill. A patient would naturally prefer that the services to him be priced in terms of the length of time he is in the hospital, regardless of whether his illness requires many or few of the services available.

It is not the cost but the uncertainty which makes hospital bills so hard to pay and so difficult to collect. Any policy that will give the incoming patient assurance as to the amount of his bill (even if it is large) will assist him in the payment of that bill. People will lend money

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to a friend for a definite amount more readily than they will promise a sum which is indefinite.

Certainty is the factor that increases and stabilizes hospital revenue under a plan of inclusive rates. The quest for certainty is the underlying drive behind public support of health insurance, even programs which yield substantial net revenues to their supporters. Certainty is the basic value of a Blue Cross plan which provides stated amounts of necessary service rather than definite cash allowances toward an indefinite hospital bill.

Hospitals might well calculate their costs and establish their charges in terms of the average costs of complete care "per day," or even "per admission." Blue Cross plans typically use the per diem basis of payment for the service benefits included in the contracts. Usually these payments are intended to cover the costs incurred by the hospitals in producing services to subscribers. A graduated scale of inclusive rates recognizes the fact that "the first ten days are the hardest."

Hospital patients are not the only persons to be considered in establishing charges for the simple reason that they are not the only people who benefit from hospitals. A hospital also serves when it only stands and waits.

Ninety per cent of the population do not receive hospital care during a given year. Yet a hospital is just as important for the 90 per cent as it is for the 10 per cent who become bed patients.

Depreciation Must Be Paid

The value of the services of hospital plant and equipment (usually called "depreciation") is just as much an item of hospital cost as are the expenditures for salaries, food or fuel. The only question is who should pay them or repay them. Logically the readiness-to-serve costs (including depreciation) should be carried by the well people, and only the operating or service costs, by the people who are ill. Depreciation is an actual cost of hospital care, which must be paid by someone, whether a small or large number of persons.

Usually depreciation is not included in the "costs" expected to be met through patients' fees. But it *could* be included. And it *should* be included in costs chargeable to any agency which represents a substantial portion of the public. Prepayment subscribers have an obligation (but no more than other patients) to contribute to capital expansion and replacement of the hospitals in their community.

Hospital plant and equipment have traditionally been provided by a relatively small group of persons, namely voluntary contributors and taxpayers. They have usually made these contributions on behalf of the "other fellow," that is, someone who ordinarily would be unable to pay even the operating costs of the hospital care he receives. It would be courtesy to these contributors if the benefits of their contribution were restricted to people of limited means. Relatively high charges for service in luxury accommodations may be justified as covering the full costs, including allowances for depreciation.

Much has been said in hospital literature about the importance of high utilization of facilities. Yet most of the emphasis has been placed upon bed occupancy, with no reference to proper use of the expensive scientific equipment and apparatus, which may be depreciating rapidly in value because of obsolescence as well as wear and tear.

A few years ago, hospitals offered low room rates as "loss leaders" in order to bring patients to hospitals —or, to put it more graciously, in order to familiarize them with the values of hospital service. But the special service charges were intended to yield a substantial net revenue to the institution.

Board and room charges have increased greatly in the last decade; special service charges are about the same as formerly. This is good for the people and for the hospital. Most of the actual increases in hospital costs have occurred in the "institutional" services, the part which is probably least essential to adequate diagnosis and treatment.

High charges for room service tend to encourage short stays, and low charges for special services tend to encourage good diagnosis and treatment. Some types of services might well be priced at a loss to encourage their use; others at a profit in order to discourage their use because they are incidental to proper diagnosis and treatment. Emphasis should be placed continuously upon the essential services which the patient receives because he "can't help it," rather than upon the services which he requests voluntarily as a matter of pride or convenience. Such a policy would tend to improve quality of service to the patient, also to increase revenue to the hospital.

Paradoxical as it may seem, low charges tend to increase hospital income from patients. A citizen has two alternatives when he considers hospital charges to be too high. He can go without care or go without paying for it. The result of high charges is often merely to increase the number of people who feel justified in asking for charity.

This principle applies to prepayment cases as well as to individual patients. If the cost of protection against hospital bills is too high (or is thought to be) many people will attempt to receive free care at the expense of the taxpayers or those who are provident enough to join health insurance programs.

Will Pay Small Amounts

Small amounts from many persons yield greater revenue than do large amounts from a few. The number of people who will pay predetermined small amounts (if they have the chance) is proportionately greater than the number of those who can afford to pay undetermined large amounts. This rule applies with special emphasis to Blue Cross and insurance programs in which combined hospital revenue regularly exceeds the amounts these same people would have paid at the times of their illnesses.

Hospitals are not competitors in the accepted economic use of the term. When administrators speak of establishing rates at "competitive" levels, they are thinking more of the effect of these rates upon their attending staffs, than of the effect upon the patients. If a patient cannot pay a $100 hospital bill, he cannot (in any real sense of the word) afford to pay $90 or $80. Purchase of hospital service is an emergency transaction so far as a patient is concerned. "Price is no object," particularly if someone else is to pay it.

A hospital patient is the full time guest of the management. He is not free to arrive or leave when he pleases. Nor does he control the types or amounts of the various services which he receives and which are

recorded on his bill. The amount which is finally charged to (or paid by) a particular patient may be quite different from the so-called regular rates. A patient's need for service, rather than the hospital's need for revenue, dominates the selection of a hospital.

Seven points may be listed as a summary and conclusions.

1. *Cost is the proper basis for establishing rates for hospital service, no matter who pays:* Individual patients may pay all or a portion of the total costs. Portions may be received from the public as represented by individual contributors, community chests, Blue Cross plans or governmental agencies. Hospital accounting executives are not always in a position to determine the pricing policies for the services of their institutions. But they have the information on which such policies can be based.

2. *Depreciation is an element of cost, no matter who pays the bill:* Capital expansion and replacement are part of the costs of hospital service whether those costs are paid by a past, present or future generation and whether they are paid through donations, taxes or patients' fees.

3. *Certainty is important to both physician and patient:* Relatively low rates for services to patients who are already paying "still less" will yield more new revenue than will additional collections from the patients already being assessed the full costs.

4. *The cost-unit for establishing charges should be as comprehensive as possible:* Inclusive rates tend to increase total revenue without corresponding increases in cost. This applies both to individual patients and to contract cases, such as Blue Cross subscribers. Adequacy of income should be measured by the average costs per day or case. Income should be appraised in terms of the amounts actually received rather than by "what might have been."

5. *Quality of service and stability of revenue justify relatively high rates for board and room care and relatively low rates for special services:* Extra charges for luxury accommodations may be justified as including allowances for interest and depreciation on invested capital. Special services are the phases of hospital care necessary to adequate diagnosis and treatment and least subject to control by the patient. Free access to "special services" by private ambulatory patients would frequently release beds for other patients and would emphasize the professional phases of hospital service.

6. *Price tags do not produce income:* They merely describe the income in terms of various services which have been performed. Prices of hospital services should encourage the best possible balance of professional service to patients.

7. *A hospital does not give service in order to get money:* But it must get money if it is going to give service. Proper records of hospital costs provide the basis for a sound program of hospital charges and financing.

This Is No Way to Win Friends

THREE years ago last February it was necessary for my daughter, aged 8, to be admitted to a New England hospital in an emergency. The family doctor had telephoned the hospital from my home and made arrangements for her immediate admission. When I arrived at the hospital I told the woman at the desk who I was and whose patient was out in the car. She told me to wait in the waiting room until I was called. After twenty minutes of waiting I again went to the desk and was very "efficiently" told to wait, in spite of the fact that my daughter was out in the car, with the temperature of the air near zero —and her own at 104. After forty-five minutes I was finally called and she was admitted.

When we arrived at the room which had been saved for her, the specialist who had been called was quite upset as he had been waiting half an hour and had been told we had not arrived at the hospital even though we had been waiting for admission. As this incident occurred during the war, I blamed things on the troubles all hospitals were having with help.

Recently, my wife was admitted to the same hospital. She was told to arrive between 1 and 2 p.m. for a private room. At 1:45 we went in and announced ourselves. We were given a chart rack with the numerous questions all hospitals ask and also a list of questions covering personal financial matters. I realize that hospitals have financial problems but just what business it is of theirs what my total income is, the amount of rent I pay, the amount I have in the bank and whether I own my house or not, I cannot understand.

This form had to be filled out in the waiting room, which was about 20 feet square. In this room were several people waiting to visit patients on the wards and five other patients who were filling out forms. One of these was a very sick boy who should have been lying down, but he waited half an hour; another was a maternity patient having pains about every seven minutes, and four others of us were filling out forms.

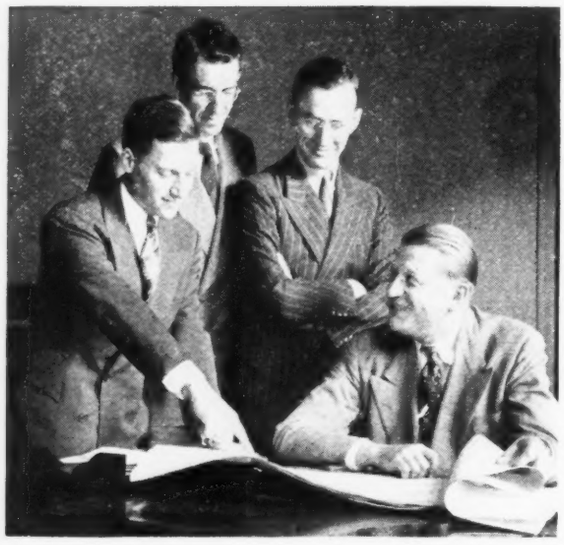
There were probably 25 people in this room, some of them were smoking, others talking and laughing and, in general, it made a poor impression on a patient coming in. After we had waited one hour we were called. The maternity patient was still waiting.

As my business is selling to hospitals, I see many of them during the week, and I have never called on this one. It would seem to me that many hospitals could improve the first impressions they make on patients and the public. To give a patient a little privacy and comfort when he enters would help. Courtesy, not efficiency, should be the first consideration. To have the first person who greets a visitor or patient do so with a pleasant word and a smile would make for a far better feeling toward the hospital. Perhaps the receptionist at the information desk is overworked so that she cannot be courteous.

Most businesses realize that the public will no longer take the kind of treatment it accepted during the war and it is now time for hospitals to realize it. The next time a member of my family has to go to a hospital I can assure you it will not be to the one in which I received the treatment I have described.—A READER.

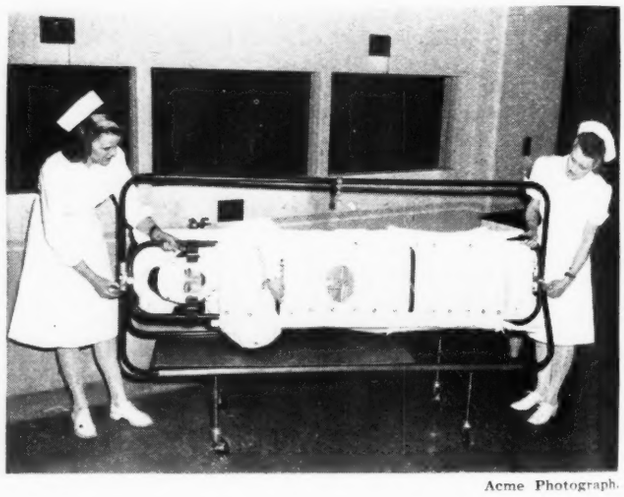
PEOPLE IN PICTURES

Above: Officers of the Minnesota Hospital Association at the May convention are, left to right: Emil Skomars, board member; Glen Taylor, executive secretary; Sister M. Thomasine, new board member; Nellie Gorgas, president; John M. Alexon, board member; Helen Eyk, second vice president; Emil Hansen, president-elect; Richard K. Fox, treasurer, and Earl Wolfe, who retired as president.



Graduate students in the newly inaugurated program in hospital administration at the University of Iowa examine plans of a proposed hospital construction project with Gerhard Hartman, professor in hospital administration. From left to right: Howard F. Cook, Northwestern University; Robert E. Riggs, University of Iowa; Wade C. Johnson, Cornell University, and Superintendent Hartman.

Below: A novel "sandwich" bed, known as the Stryker frame, permits nurses to move a fracture patient easily and quickly. Heart of the bed is a mattress that rotates within a frame. When the patient is on his back, a second mattress is placed tightly over his stomach and fastened by wing nuts at the ends of the frame. With the patient thus "sandwiched" between the mattresses, nurses at each end simply flip bed and patient over.



Acme Photograph.

Col. Harry Brown of the Veterans Administration (at microphone) addressing the American Surgical Trade Association. Listening are: John H. Hayes, George Bugbee, J. Douglas Colman of Maryland Blue Cross, Herbert Crowley Jr. of the A.S.T.A., and Dr. Vane Hoge of the United States Public Health Service.

SMALL HOSPITAL FORUM

Salaries Are Still Climbing

GENERAL duty nurses and nursing supervisors have enjoyed the largest salary increases over the last year in a group of small hospitals surveyed on the subject of salaries paid to 15 different classifications of employe.

Laboratory technicians, cooks and kitchen maids enjoyed the next highest wage increases in these hospitals in which the general average of salaries paid to all classifications of help has increased 11 per cent in the last year.

The hospitals participating in this forum are widely separated as to location and type of community, a fact which accounts for wide variations in salary schedules for the various classifications of employe. For example, salaries paid for general duty floor nurses vary from $100 a month, in one instance, to $224, as shown in the accompanying table. Similar variations between low and high salaries paid in these institutions exist in nearly every job covered in the survey. All the figures shown here include whatever maintenance perquisites are provided, expressed in terms of cash.

The salary increases given in the last year, as shown in the table, are an average figure for all the hospitals participating in the survey. Actually, about a third of the hospitals in this group have not increased any salaries during the last year and only four of the hospitals have given increases to all employes.

Among the other hospitals, a few have provided flat increases of from 10 to as much as 30 per cent for all classifications at some time during the last year. Others have given increases in varying amounts to different groups. As shown in the table, the average increase for most of the groups of employes is around 10 per cent. One institution, however, has increased salaries for general duty nurses 87 per cent during the last year. At this institution nursing supervisors have been given a 78 per cent increase and other employes are still getting the same wages they were paid a year ago.

While the variations from hospital to hospital, as already noted, are wide in each job classification, the ratios of salaries paid to various classifications of employe within the hospital remain fairly uniform in this group. Notable exceptions are one hospital in which the chief cook and the bookkeeper are paid more than are general duty nurses; another hospital in which the cook is paid more than anybody else except the administrator, and a third which lists bookkeepers next to nursing supervisors as the highest paid talent on the pay roll.

While the salary increases paid to general duty nurses and nursing supervisors are considerably more than those granted any other type of worker there is some indication in the replies to this forum that the nursing shortage is easing in this group of hospitals.

"We have not experienced any real shortage of general duty nurses during the last year," one administrator states, for example. "We have, however," he adds, "had great difficulty in obtaining the services of personnel adequately prepared to do clinical teaching and supervision. Our biggest problem and one that amounts to a real crisis today is lack of domestic staff."

Additional evidence that the peak of the nursing shortage may be passed is the fact that one third of these hospitals now have staff nurses on a working week shorter than the still prevailing 48 hours. A 44 hour week for nurses is reported by several of the hospitals in this group and in one hospital nurses are working only 39 hours a week.

It should be pointed out, however, that the hospitals which have cut nursing hours under 48 have done the same for other classifications of

MONTHLY SALARIES PAID IN SMALL HOSPITALS

Job	Lowest Salary*	Highest Salary*	Av. Salary All Hospitals	Av. Pct. Salary Increase Last Year
General duty nurse	$100	$224	$169	17
Nursing supervisor	135	284	198	17
Nurse anesthetist	175	240	208	None
X-ray technician	100	240	167	7
Laboratory technician	100	275	177	10
Orderly	110	180	138	9
Ward aide	65	152	106	9
Housekeeping maid	63	132	96	9
Dietary maid	63	143	100	10
Chief cook	112	258	154	10
Bookkeeper	105	211	159	9
Stenographer	85	143	117	8
Laundry worker (male)	82	200	149	8
Laundry worker (female)	75	127	99	8
Telephone operator	75	144	108	6

*Includes perquisites expressed in cash.

employe for the most part. In some instances, as a matter of fact, in which nurses are working a 44 hour week, housekeeping and office personnel are working only 40 hours.

A little more than half these hospitals do not anticipate that further salary increases will be required during the coming year, although some of these acknowledge that some increase may nevertheless be needed. Other hospitals in the group frankly state that wages will continue to mount and indicate that the only way such increases can be financed is to charge more for patient accommodations and services. "Unfortunately," says one administrator, "this appears to be the only solution." He referred to the necessity for raising rates to meet mounting salary costs.

Answers to still another section of the forum indicate plainly that the organization of hospital employes into unions or other collective bargaining groups has definitely not penetrated to the small hospital outside the metropolitan area. Only two of the hospitals in this group have any kind of collective bargaining arrangement with any group of employes. In one of these instances the hospital deals with its nurses through their state association, now the official bargaining agency. In the other, collective bargaining with the nursing group was instituted by agreement between the administration and the hospital nurses themselves.

That Employes May Work Together

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IN ANY undertaking in which many individuals combine their efforts as they do in Hurley Hospital, Flint, Mich., it is only natural that certain procedures and fundamental guiding policies evolve gradually out of the practical day to day affairs. One of the most important factors which influences the progress of the hospital is the ability of the employes of that hospital to work together efficiently and effectively.

Over the years the employes at Hurley Hospital have achieved an enviable record in this respect; however, the board of hospital managers believed that a great deal of advantage could be gained for employes in their relations with one another and in their contacts with the general public by an organized program of personnel service designed to promote a better understanding of the aims and objectives of Hurley Hospital.

Herbert A. Schacht, formerly a business manager of a small general hospital, who was for some time associated with the business office of Hurley Hospital, was appointed director of this service. Each employe is invited to cooperate in this program which was established for the single purpose of doing a good job better.

The activities of the personnel service department include the following:

To Maintain a Program for the Education of Employes in Good Personnel Relations

1. Employe-Public: This entails a program for all employes and, in particular, those who have direct contact with the public.

2. Employe-Employe: This program includes planning group events and organizing recreational activities which will develop good relations among employes.

To Interpret Procedures to Employes

This is a continuing program. When an employe makes a request to a supervisor for information regarding a hospital procedure, that supervisor routes the employe to the personnel service department. The purpose of this policy is twofold: first, to save the time of the supervisor and, second, to maintain a central information service.

To Maintain an Orientation Program

This program was organized for old as well as new employes; as older employes gained insight into the aims of the hospital, however, the program was directed solely to new employes. The purpose of this program is to familiarize employes with the aims and purposes of the hospital. The first class in the orientation program covers a period of approximately two hours and includes a tour of the hospital.

To Maintain a Counseling Service

1. Opportunities for advancement: The personnel service department maintains a record of the employe's previous training and experience for reference in determining his eligibility for advancement and counsels with the employe regarding opportunities for advancement.

2. Personal matters: Some employes prefer to discuss personal matters with someone other than their immediate supervisor. The personnel service director's office may be used for counseling employes on personal matters.

To Publish a Four Page Monthly News Letter for Employes

1. Front page: The front page is used to convey special information to employes.

2. Editorials: At least one editorial is devoted to information of special interest to employes.

3. May We Introduce: In this division we announce the names of new employes.

4. Facts: This division is used to tell employes something about the service of Hurley Hospital.

5. A Message: This division is used for printing a message which may be written by a member of the governing board, the medical staff, the head of a department or any other member of the hospital personnel.

6. Roving Reporter: This is a novelty feature which is proving of interest to our employes.

7. Briefs: We have several short paragraphs under this caption which we believe are of interest to our employes. Also in this division are listed the "personals."

8. The caption of this division is the title of some department or division of a department. In this feature we give a brief account of the activities of the division in order that our employes generally may have a better knowledge of Hurley Hospital.

9. Meetings: Many of our employes are members of organized groups, such as the District Nurses' Association or the City Employes' Club. In this division we list the regular monthly meeting dates of such organizations.

There is one major difference between the functions of our personnel service department and what ordinarily would be assigned to this service in most other hospitals, that is, the personnel service director has nothing to do with the recruiting of personnel. Hurley Hospital is a subdivision of the Flint city government and all employes work under local civil service.

The Civil Service Commission does all recruiting of employes for the city of Flint. Each department is set up on a quota system of regular full time employes. In cases of vacancies the department head fills out a requisition to cover the vacancy. This requisition is reported to the director of civil service. Under the provisions of civil service, the department head is entitled to three candidates for each vacancy; however, it is not always possible for civil service to furnish three candidates for each vacancy.

The department head interviews the candidates and makes the selection of the one to fill the vacancy. After the department head has made the selection, that employe is directed to the office of the personnel service director. This is the first contact the personnel service director has with the new employe, and it is at this point that the director begins the orientation program.

The following services are completed during the first twenty-four hours of employment: (1) an appointment is made for the required physical examination; (2) an appointment is made for the required chest x-ray examination; (3) assistance is provided in helping the new employe make out his withholding tax form; (4) the new employe is requested to fill out a two page form which is used for reference for eligibility for advancement to higher level positions; (5) the employe is given a little booklet entitled "You and Your Job in Hurley Hospital."

This booklet contains a brief history of the hospital and lists certain pertinent information with reference to the employe's responsibilities and opportunities with Hurley Hospital and also lists most of the employe procedures now in effect. The orientation classes follow later and are held only when there is a group of at least five new employes.

Thus far, the results of the program have been encouraging.

Hospitals in New Zealand

THERE has never been in New Zealand such a setup of voluntary hospitals as obtains in England and the U.S.A. Prior to the present Social Security Act's coming into force in 1939, the provision of hospital accommodations in New Zealand was approximately as follows: public hospitals, 85 per cent, and private hospitals, 15 per cent. It is still much the same today, but with a definite prospect of there being no expansion but rather a diminution in private hospital accommodation owing primarily to high costs of building and maintenance.

Since 1908 New Zealand has been divided into some 40 hospital districts. In each district is a hospital board whose members are elected by popular vote for a period of three years. There is a central body, the public health department, which exercises a broad general control. The boards carry out their functions in terms of the Hospital and Charitable Institutions Act, 1926, and its amendments.

Every person was entitled to admission to the public hospitals and up to 1939 was required to contribute to the cost of maintenance in accordance with his means, the usual daily rate charged being $3 a day plus extras for such items as x-ray tests.

The boards each year estimated what their total expenditure would be; from this they deducted what they expected to receive from patients' fees, donations and any other income and the net deficit was then met by levies on the local authorities comprising the hospital district and by a government subsidy.

The same method of finance is still adopted, but now instead of receiving fees direct from patients these are paid by the government from the Social Security Fund. The following statement summarizes the sources from which the board will obtain the necessary finance for the year 1946-47 for maintenance and capital:

	Per Cent of Income
1. Credit balance in bank accounts	3.72
2. From sundry fees, collections and other income, including government subsidy	5.48
3. From Social Security Fund and war expenses account for patients treated	41.20
4. From levies on local authorities	23.09
5. From government subsidy on levies	26.51
	100.00

Private hospitals had to charge such fees as would pay them to carry on.

Since 1939 patients in public hospitals are not charged fees, each board being paid $2.25 a day for each patient by the government out of the Social Security Fund. Private hospitals also receive this $2.25 a day but have to reduce their charge to the patient correspondingly.

To date, the fact that treatment is entirely free in public hospitals has had no effect on admissions to private hospitals. No one can say what the position would really be in normal circumstances; things have been abnormal ever since Social Security came in. During the war years beds in public hospitals were grossly overcrowded, now there are empty beds but insufficient nursing or domestic staffs to keep them going. We have more than 2000 patients on our waiting lists and some 500 empty beds out of a total of 2300 beds at our four main institutions.—AUCKLAND HOSPITAL BOARD, *Auckland, New Zealand.*

ABOUT PEOPLE

Dr. Herman E. Hilleboe, assistant surgeon general of the United States Public Health Service and associate chief of the Bureau of State Services, U.S.P.H.S., has been named commissioner of the New York State Department of Health. He succeeds **Dr. Edward S. Godfrey Jr.,** who retired recently. A graduate of the University of Minnesota School of Medicine with a degree in public health from Johns Hopkins School of Hygiene and Public Health, Dr. Hilleboe has been engaged in public health work since 1935, specializing in tuberculosis control. He was appointed senior assistant surgeon in the regular corps of the Public Health Service in 1939 and served with the Minnesota Division of Social Welfare in St. Paul from 1939 to 1942, on loan from the U.S.P.H.S.

Dr. Hilleboe was appointed chief of the Tuberculosis Control Division, U.S.P.H.S., with the rank of medical director in 1944. In November 1946 he was appointed associate chief of the Bureau of State Services, with the rank of assistant surgeon general.

Administrators

Dr. W. L. Shackelford, formerly administrator of South Mississippi Charity Hospital at Laurel, has been named director of Mississippi State Hospital, Whitfield. Dr. Shackelford is the new president of the Southeastern Hospital Conference.

James H. Murphy assumed the duties of administrator of Bayonne Hospital and Dispensary, Bayonne, N. J., on July 1.

Walter M. Oliver has been appointed administrator of Children's Hospital, San Francisco, succeeding the late **Charles A. Wordell.** Mr. Oliver has been business manager of the hospital for six years. He is a member of the A.H.A. committee on accounting and is past president of the hospital economics section of the Association of California Hospitals. Prior to his appointment as business manager of the Children's Hospital, Mr. Oliver was director of the bureau of audit and statistics of the San Francisco Community Chest.

Charles V. R. Wynne, assistant director of Grace-New Haven Community Hospital, New Haven, Conn., will assume the directorship of Waterbury Hospital, Waterbury, Conn., on September 1, succeeding **Aida Creer.** Mr. Wynne will retain his post as clinical instructor in hospital administration at Yale University. He went to New Haven Hospital in 1945 with a master's degree in hospital administration from the University of Chicago and was appointed assistant director in 1946.

Boone Powell has been appointed to the newly created office of assistant administrator of Baylor University Hospital, Dallas, Tex. He has been associated with the institution for two years, first as office manager and later as business manager. In the capacity of assistant administrator Mr. Powell will supervise the business office, personnel, maintenance and purchasing departments.

Announcement has also been made of the resignation of **Andrew Q. Allen** as assistant to the administrator of Baylor. Mr. Allen served for three years, first as business manager and later as assistant to the administrator, handling public relations and personnel. He has accepted the position of director of public relations of the Baptist General Convention of Texas.

William G. Yates is the new administrator and business manager of Bowie Clinic Hospital, Bowie, Tex., replacing **Mrs. Ann Starr. Mrs. Thelma Kalhoefer, R.N.,** has been designated assistant administrator.

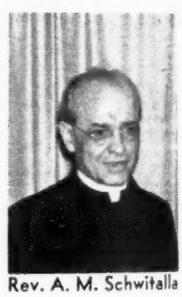
Dr. Robin C. Buerki, dean of the graduate school of medicine at the University of Pennsylvania and director of the University Hospital in Philadelphia, will receive the 1947 Award of Merit of the American Hospital Association. The award will be made at the American Hospital Association convention to be held in St. Louis next month. Dr. Buerki, who is a past president of the association, is the ninth man to be honored with the award.

Col. Victor N. Meddis has resigned from the position of superintendent of Robert B. Green Memorial Hospital, San Antonio, Tex.

Helena R. Hughes has been named superintendent of Riverside Hospital at Paducah, Ky.; she assumed her new duties on August 1.

Daniel M. Brown, a graduate of the Northwestern University course in hospital administration, and former administrator of Shasta Dam Hospital, is now administrative assistant at Permanente Hospital, Oakland, Calif. During the war Mr. Brown served in the hospital corps of the navy with the rank of lieutenant (j.g.).

Bruce Dickson, who recently finished his academic work in hospital administration at Northwestern, has accepted the position of administrator of Bethany Hospital, Kansas City, Kan.



Rev. A. M. Schwitalla

Rev. John Joseph Flanagan, S.J., president of Regis College, Denver, has been appointed executive director of the Catholic Hospital Association to succeed **Rev. Alphonse M. Schwitalla, S.J.,** dean of the university's school of medicine. Father Schwitalla will continue as director of the programs in nursing education and hospital administration and as editor of *Hospital Progress.*

Dr. Jack Sharpe has been appointed to the superintendency of Toronto General Hospital, Toronto, Ont. During the war Dr. Sharpe served with the Royal Canadian Air Force.

S. A. Ruskjer, administrator of Waverly Hills Tuberculosis Sanatorium, Waverly Hills, Ky., has taken on the additional responsibilities of deputy director of health in charge of hospitals for Louisville and Jefferson County. He will divide his time about equally between the two posts.

Victoria Smith, who has been associated with Englewood Hospital, Englewood, N. J., for the last twenty years and has been its superintendent for the last twelve years, has been given a leave

(*Continued on Page* 154.)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

What Is the Right Pattern for the Board?

J. HAROLD JOHNSTON
Executive Director
New Jersey Hospital Association

NOT only must the hospital interpret its purposes and functions to the public but the need of the community for health services must be interpreted to the hospital. Consequently, hospitals have been adding to their boards men and women with somewhat more than a casual acquaintance with the social problems and the welfare needs of their communities.

In some instances, those with special knowledge in these fields have been sought as well as those serving on boards of other health agencies, so that integration of purposes could be accomplished more easily.

Boards Are More Representative

Boards are becoming more representative of the communities they serve. One hospital that I know of has deliberately sought board members of different religious faiths because of the realization that the hospital was serving the entire community and, therefore, the point of view of those of other religious beliefs should be represented. Community chests and certain social agencies have been adding labor leaders and members of minority groups to their boards for the same reason.

Again, interpretation and community representation have caused some hospitals to adopt the principle of limiting the number of terms a trustee may serve. Thus, more people, over a given period of years, can become acquainted with the hospital from the inside and thereby interpret its policies and needs to their friends and neighbors and, at the same time, more segments of the community can be represented on the board than would otherwise be the case. This would seem to be especially true of hospitals that have small boards.

Some hospitals now look to the people in surrounding municipalities for financial support and, of course, residents of these municipalities are admitted as patients. These facts have led some hospitals to adopt the limited term plan so that trustees can be chosen in rotation from these other communities, thereby giving local emphasis to the desired support. It may be that as the financial base of hospital support is widened the matter of wider trustee representation will become more compelling.

The plan of limiting the number of terms has the obvious disadvantage of eventually rotating off the board some especially well qualified trustee and may cause some lack of continuity in board policies depending upon the number of terms permitted. These disadvantages may be overcome, at least to some degree, by continuing former presidents as ex officio members of the board with full vote.

One hospital trustee recently advanced the theory that the average age of board members should be taken into account in selecting new members. It was his opinion that the average age should be 35 years and, thus, as the older members retire, their places would be filled by those of an age which would maintain the average. This method would preserve a desirable balance between the younger and older points of view and at the same time retain the advantages of long term membership which he thought might be lost in the rotating system.

Hospitals today are far more complex institutions than they were. The problems faced by trustees today are correspondingly more complicated. This fact has brought other changes in the composition of hospital boards.

Such matters as public relations, personnel policies, education of student nurses, training of employes, accounting procedures, social service activities and purchasing principles are now to the fore and trustees, of necessity, must be concerned with them. The need for expert guidance in these fields has caused hospitals to place on their boards citizens with special knowledge and abilities, men and women who can assist the administrator and the trustees in solving problems and in preparing policies of a technical nature which require specialized training and experience.

The complexity of management and policy making today has likewise caused some hospitals to reduce the numerical size of their boards in the belief that a smaller working body tends to increase efficiency.

Corporate Structures Vary

There is a wide diversity in the corporate structure of nonprofit hospitals. Some are organized as membership associations and the trustees are chosen by the votes of those who have paid the membership fee. In other instances, financial contributors have the voting privilege. Most hospitals, however, have a self perpetuating board of one kind or another which is the continuation of the original group of incorporators. These management boards may be small or large, ranging from as few as five members to as many as 75. When the number is large, the direction of the hospital's affairs is usually vested in an executive committee with the parent body meeting annually or, in some instances, more frequently.

The experience of one hospital incorporated some 65 years ago may be of interest. Recognizing the need for better public relations, or "interpretation," this hospital set up by

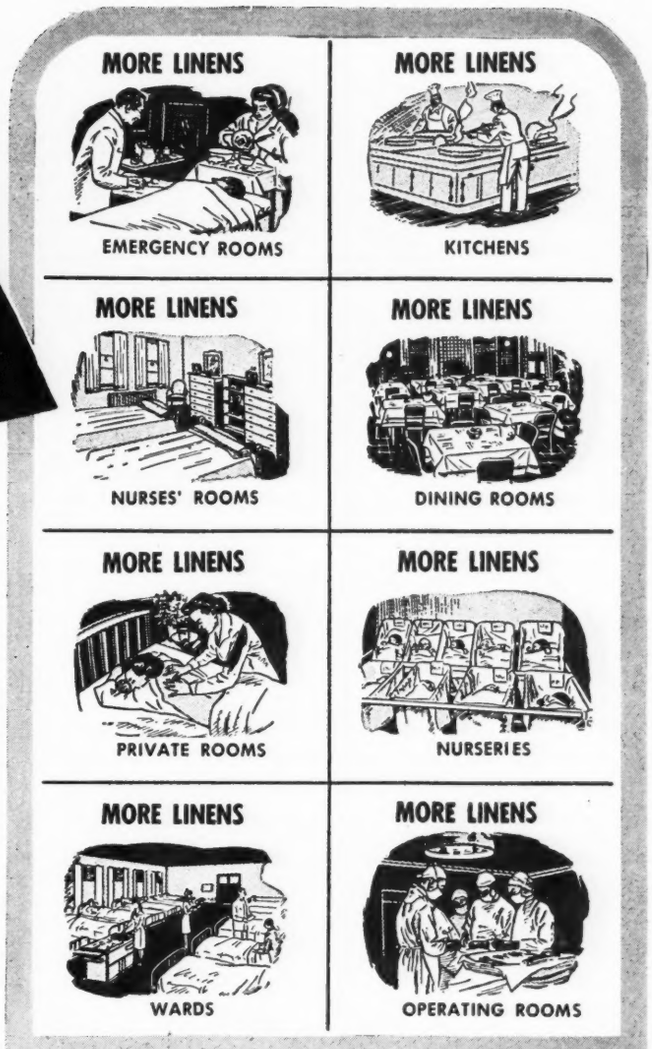
From a talk delivered before the Trustee-Administration Institute, New Jersey Hospital Association, 1947.

"STINGY"

Been forced to ask your staff to economize on linens—even at expense of patients' comfort? The trouble is in the laundry, seriously overburdened by demands of increased occupancy.

A *modernized* laundry will give you all the additional clean linens you need. Today's high-speed laundry machines turn out more work in less time. Quality of work is greatly improved. Faster laundering returns linens to service on shorter schedule. You need less linen inventory. Yet all departments have plenty of linens for emergencies. And you save money through reduced production costs.

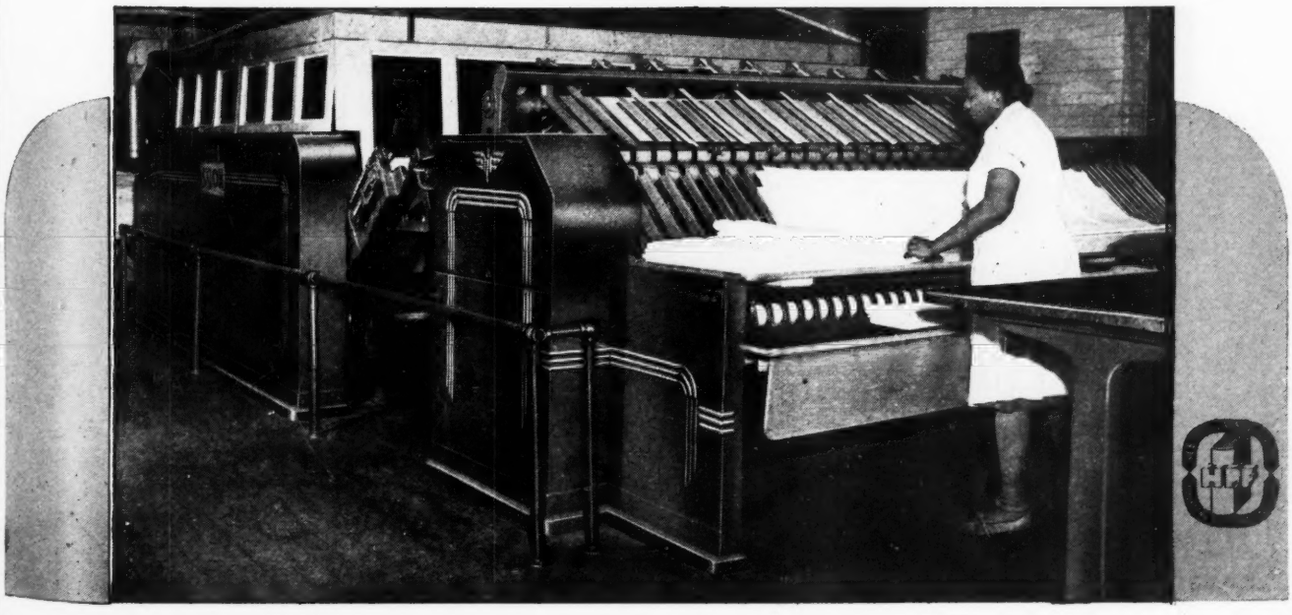
Think it over. Every department must have a plentiful supply of clean linens to function properly. Ask for a free survey with recommendations by our Laundry Advisor. WRITE TODAY.



REMEMBER . . . Every Department of the Hospital Depends on the Laundry

THE AMERICAN LAUNDRY MACHINERY COMPANY
CINCINNATI 12, OHIO

● *Installation of modern 8-Roll SYLON Flatwork Ironer with TRUMATIC Folder—irons linens beautifully at high speeds and folds large pieces automatically, with big labor-savings.*



proper legal procedure a large group of some 60 citizens to take the place of the previously constituted management group. The new group, which, like the old, is self perpetuating, was called the board of directors. The directors, in turn, elect a board of trustees of 15 individuals which exercises the management function and reports annually to the "big board." It will be observed that this plan resembles the association method of organization but retains the self perpetuating aspect with respect to the final authority.

Aware of Complexities

An interesting development of recent years has been the interpretation of the hospital to the members of its own board of trustees. The awareness on the part of trustees that hospital management is complex and that the function of the board is more than the mere operating of a specialized type of hotel has created a desire on the trustee's part for a better understanding of the hospital's organization, methods of operation, internal and external relationships and developments in the field as a whole. The new trustee especially seems to be conscious of his lack of knowledge and understanding.

The result has been orientation programs of one type or another. Organization charts are sometimes given the new trustee which indicate the lines of authority within the hospital and the relationship of departments to one another. Brief written descriptions of the functions and organization of the medical staff and medical services as well as of the various departments are helpful.

A somewhat leisurely but thorough inspection from the storerooms to the penthouse by the new trustee and the administrator is enlightening, especially if the administrator will discuss the functions, problems and plans for the departments they visit. It is not a bad procedure for trustees older in service to follow now and then. Introducing the trustee to department heads tends to "personalize" the department in the trustee's mind and is good personnel relations for the department head.

Many hospitals distribute to their trustees reprints of articles appearing in the hospital magazines. Some hospitals subscribe to one of the hospital publications for each board member. The number of personal memberships in state associations is likewise on the increase and the attendance of trustees at the annual conventions of state and regional associations is exceeding all previous figures.

Perhaps the most nearly complete orientation method in use today is the trustee seminar. These seminars take various forms, depending upon local conditions, and they vary in content for the same reason. The one with which I am most familiar grew out of a specific request from board members. They offered to give four hours of their time, including the dinner hour, to the project.

Immediately following the adjournment of the regular board meeting at 5 o'clock, the administrator took over and discussed the general organization of the hospital, distributing copies of the organization chart. He was followed by the chief of staff who outlined the organization of both the medical staff and medical service. Most of his talk was devoted to a frank and critical appraisal of the professional departments. Question periods followed each talk.

The group was joined for dinner by the director of nursing, the dietitian, the executive housekeeper and the comptroller. After dinner, these four department heads outlined the activities of their respective departments in ten minute talks, questions being invited after each talk. The administrator rounded out the picture by reviewing the functions of the adjunct departments. Adjournment took place promptly at the promised time of 8:30. As the members left, copies of the pamphlet "The Governing Board of the Hospital" prepared by the American Hospital Association, were given them as "homework."

Another source of orientation is for the administrator to give information at board meetings about the day by day activities of the hospital in addition to whatever more formal report he may make. Comment about unusual medical or surgical cases, news about the personnel and human interest items all help to give a full understanding.

Can Interpret Trends

The administrator also has an excellent opportunity to present trends and developments in the hospital field as a whole and matters pertaining to the health and welfare of the specific community, provided the board will give him the necessary time, say ten or fifteen minutes at each of three or four meetings a year. The need for better care of the chronically ill and those having communicable diseases and also for some types of mental diseases, the hospitalization of veterans in community hospitals, the recommendations of the Commission on Hospital Care, the national health bill and the Murray-Wagner-Dingell proposals are among the current subjects worthy of discussion.

We have observed that, as hospitals have become more closely integrated into the life of a community and as the problems of direction have become more complex, changes have come about in the composition of hospital boards of trustees. The extent, if any, to which it may be desirable for a particular board to study its own organization or composition in the light of the changes reported would be determined by its own appraisal of the underlying causes and its own judgment concerning the objectives to be gained.

MEDICINE AND PHARMACY

Stabilizing the Medical Staff

HAROLD C. LUETH, M.D.
Dean, University of Nebraska College of Medicine, Omaha

LARGE shifts in the personnel of hospital staffs occurred during the war, and even larger shifts are occurring at the present time. Reconversion is a major problem of industry and has its counterpart in medical and hospital service. Young doctors have been qualifying for specialty training in larger numbers than ever before. The greater share of active medical practice is usually carried on by young medical graduates and middle aged practitioners, inasmuch as older physicians and surgeons confine their work largely to consultations, office and hospital practice. Hospitals, therefore, have a distinct problem in fitting the younger men into existing organizations.

Bigger Staff—Fewer Beds

Increased admissions to hospitals as a result of wider participation in voluntary insurance programs, wider acceptance of hospital facilities following a long educational program and increases in the knowledge of medical science have combined to keep existing hospitals filled to capacity most of the time. Thus the hospital administrator is asked to accomplish the nearly impossible task of enlarging the hospital staff and at the same time apportioning fewer beds to each staff member.

Stabilization of any organization will do much to help in the formulation of long range plans and in the carrying out of sound operational policies. Since hostilities have ceased and medical officers have returned to civilian practice, the enlargement of hospital staffs has caused no small amount of unrest. Some thought should be given to the extent to which we can anticipate an enlargement of hospital staffs.

The large number of young medical officers currently taking training in specialty programs and the number of those who have already qualified themselves as specialists indicate that the old balance between general practitioner and specialist has been modified considerably in the direction of more specialists. It should be recognized that there are more specialists available to do medical practice than there were in the past and that hospital staffs must be formed about these specialists.

A number of problems will arise with a larger proportion of specialists on a hospital staff. There must be a thoughtful review and a careful appraisal of the methods of referring patients from one specialty group to another. Special examinations, such as proctoscopic, ophthalmoscopic and bronchoscopic, are requested oftener than was the case prior to World War II. Hospital administrators must be alert to these changes and provide more facilities for the performance of the special types of examinations.

With a larger number of specialists there will be more frequent consultations between practitioners. More comprehensive laboratory and x-ray testing of patients will inevitably follow a program of more consultations. The problems of charges to patients and other financial aspects of the situation are vexatious and must be realistically met.

The pathologist and radiologist of the hospital deserve careful consideration in the light of the new alignment of work loads of personnel within the hospital. It is axiomatic that when more and better trained doctors examine and treat any given number of patients there will be more requests for laboratory and radiologic examinations. All hospital administrators are acutely aware of the constantly increasing number of laboratory and x-ray examinations that are being requested by the staff.

For example, a study of a number of patients treated at the University of Nebraska Hospital from July 1946 to December 1946 showed that 15 per cent more laboratory examinations were requested during that period than were requested for the same number of patients in a similar period the previous year. Requests for radiological examinations have practically doubled within the last eighteen months. Some delays and bottlenecks in hospital treatment are encountered in the departments of clinical pathology and radiology. It must be recognized that as the hospital staff grows these two departments will also have to show a comparable augmented growth.

Indications for Growth

There are several indications for growth of the departments of pathology and radiology. First, the normal increase in the number of requests by each physician on the staff; second, the larger number of specialists requesting additional detailed examinations; third, the growth and development of the medical sciences leading to more tests that yield greater information in specific cases.

It is not unlikely that further increased costs for hospital care will occur as a result of the growing number and cost of laboratory and radiological examinations. Within a reasonable time stabilization probably will come about within the economic structure of the country so that the cost of food, supplies, salaries and equipment will remain fairly constant. However, there is every reason to believe that the cost of hospital care in the laboratory and radiological fields will continue to rise. Hospital staffs are organized for

Given at the sectional meeting of the American College of Surgeons, March 1947, Omaha, Neb.

efficient operation and can best accomplish their aims by enlisting the support of representatives from each of the larger fields of activity. Traditionally, the medical staff of a hospital is composed solely of physicians who determine medical policy. With the increased growth of medical knowledge and the necessity for nursing and ancillary technical personnel, it seems advisable to include representatives from those groups in the medical staff organization. Much can be accomplished in promoting harmony and smooth operation by inviting a representative from the nursing staff, dietary department, medical social service department, physical therapy department and occupational therapy department to be included as active members of the medical staff.

While to some this may seem a radical departure from the long established policy, after an initial trial period most physicians will find that many of their petty grievances, vexations and difficulties can be smoothed out and greater understanding can be reached by the addition of ancillary groups. It is not necessary or even advisable to include representatives of the related services in all of the medical staff meetings, but, periodically, at least quarterly, it would be wise to have a combined medical and ancillary group meeting.

Large numbers of people seeking hospital care for the past several years have created difficult and troublesome problems to the hospital administrator. Inasmuch as it appears that a satisfactory or comprehensive hospital building program cannot be completed within the next several years, it would be well to give some thought to the problem of hospital admissions. Each individual hospital administrator and staff must work out a technic that is mutually satisfactory and consistent with the customs and practices of the community.

It would be well to acquaint the public with the acute hospital bed shortage rather than continually to temporize, as has been done for the last three or four years. In this connection it should be remembered that many returned medical officers are currently in hospital training programs and within the next two or three years they will probably resume civilian practice and be eager to have hospital facilities available.

The large number of returned medical officers in residency training programs unmistakeably points the way to a large number of specialists for the future. Many of these men have been accustomed to working with and referring patients to other specialists during their service with the armed forces. It is believed that these work patterns will be carried over into civilian practice.

The place of the general practitioner in the midst of this changing medical practice is difficult to surmise. Physicians now engaged in general practice will undoubtedly be continued on their present hospital staff appointments. The desirability of a hospital appointment and the scarcity of available hospital beds have made most hospital staffs reluctant to appoint new members to their attending staffs. In many situations of scarcity the rewards will go to those best qualified and most deserving.

While no specific rule can be given, there is every likelihood that hospital staffs will appoint future members from the ranks of physicians who are most thoroughly qualified. Rural and small community hospitals will probably continue to have a greater number of general practitioners on their hospital staffs than specialists.

The comprehensive program of hospitalization as envisioned in Public Law 725 may have a secondary effect on the placement of the general practitioner in the hospital system. Under the contemplated plans, the health center will probably be manned by general practitioners with the assistance of nurses, dentists and a sanitarian. The regional hospitals will also have a staff composed largely of general practitioners.

Radiological and laboratory service to regional and district hospitals will probably be furnished by occasional visits from trained physicians from the central or base areas. When adequate laboratory and radiological facilities are developed in a district hospital, the institution will become attractive to certified specialists in surgery, internal medicine, orthopedic surgery, pediatrics, obstetrics and gynecology and other fields. The quality of the radiological and pathological service of a hospital will be mirrored to a large extent in the development of a strong hospital staff. When laboratory and x-ray facilities are poor, the staffs will be composed largely of general practitioners. When there is readily available expert radiological and laboratory service, the staff of the hospital will attract a larger number of specialists and will thus be strengthened.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Local Anesthetics

THROUGHOUT the long history of medicine, one of the primary objectives has been to find ways and means to produce insensibility to pain. Therefore, it is not surprising that in looking for a substitute for morphine, Koller and Freud in 1884 discovered that another alkaloid, cocaine, while disappointing as a narcotic, possessed remarkable local anesthetic properties.

The search for less toxic local anesthetics begun in 1902 with the synthesis of procaine by Einhorn still goes on. None of the present drugs, however, can be considered as the ideal local anesthetic. Such an agent should have the following properties:

1. It should be easily water soluble and stable in solution.
2. It should be nonirritating upon local application or injection.
3. It should produce anesthesia without damage to nerve structure.
4. It should have a low systemic toxicity, since it is absorbed from the injection site.
5. It should have a short induction period and a duration of action suffi-

ciently long to allow ample time for surgical procedures.

6. It should penetrate mucous membranes when applied locally.

7. It should have no after hyperesthesia, *i.e.* temperature felt as pain or touch felt as soreness.

8. It should have a vasoconstrictor effect or be compatible with epinephrine.

Although local anesthesia may be produced by the application of cold to tissues, by ischemia, by pressure on a nerve trunk or by irritants which injure or kill the nerve endings, drugs are the safest and most reliable agents. Their safety and practical value lie in the fact that they are noninjurious to nerve fibers and cells and their action is completely reversible.

To determine the potency and duration of anesthesia of these drugs, they are tested on the mucous membrane of the human tongue, on the frog sciatic nerve, on the cornea of the rabbit's eye and by intradermal wheals formed in the skin of the guinea pig and man. The concentration at which convulsions occur in mice and rabbits is further determined to calculate the therapeutic index for each drug.

Properties of Local Anesthetic Drugs

The exact mechanism of action of local anesthetic agents is not known; however, all affect nerve tissue in the same way by blocking sensory nerves earlier than motor nerves. The rate and degree of penetration seem to be in direct relation to the size of the nerve fiber and the absence or thickness of the myelin sheath. Transmission of nerve impulses is also blocked at the myoneural junction, at the sensory-organ nerve junction and in the ganglia of the autonomic nervous system. The action of local anesthetics is potentiated by alkali; the free base is the active form which affects nervous tissue.

The vasoconstriction produced by epinephrine at the site of injection decreases the rate of absorption of the drug and allows the detoxifying mechanisms of the body to keep pace with the rate of absorption and thus prevents toxic concentrations. All local anesthetics are destroyed in the liver, some more rapidly than others. For this reason, large quantities such as are used for extensive block anesthesia should not be injected into a person with known liver damage.

All are convulsive poisons. They produce central nervous system stimulation, consisting of restlessness, tremors and clonic convulsions followed by depression. Death is usually due to respiratory failure. In rare instances allergy to these drugs exists, so that injection of even 1 cc. of a 1 per cent solution of procaine, as used in dental surgery, may produce cardiovascular collapse and death. To counteract the toxic action on the central nervous system, barbiturates are most effective. Not only do they arrest convulsions but when given prophylactically they provide protection against the convulsive syndrome. If convulsions occur, a short acting barbiturate, sodium pentothal, is given intravenously in small symptomatic doses. Prophylactically, barbital 0.5 gram or phenobarbital 0.2 gram is given the night before or pentobarbital 0.2 gram may be given two hours before surgery.

Methods of Administration

1. Surface anesthesia. Aqueous solutions of the salts of commonly used local anesthetics do not penetrate the intact skin. Their bases in ointments do penetrate to a limited extent and have been applied to wounds for the relief of pain. However, this is not advisable since the resultant tissue damage may delay healing. Topical application of those agents which penetrate the mucous membranes is the commonest method of producing anesthesia of the bladder, urethra, nose and throat and cornea of the eye.

2. Infiltration anesthesia brings the drug into direct contact with the nerve endings. Injections may be made intradermally with a 27 gauge needle into a small skin area in order to facilitate the introduction of larger needles used for transfusions or spinal puncture. Injection may also be made deeper into the subcutaneous tissues in a ring about the site of operation to block all sensory nerve endings in this area.

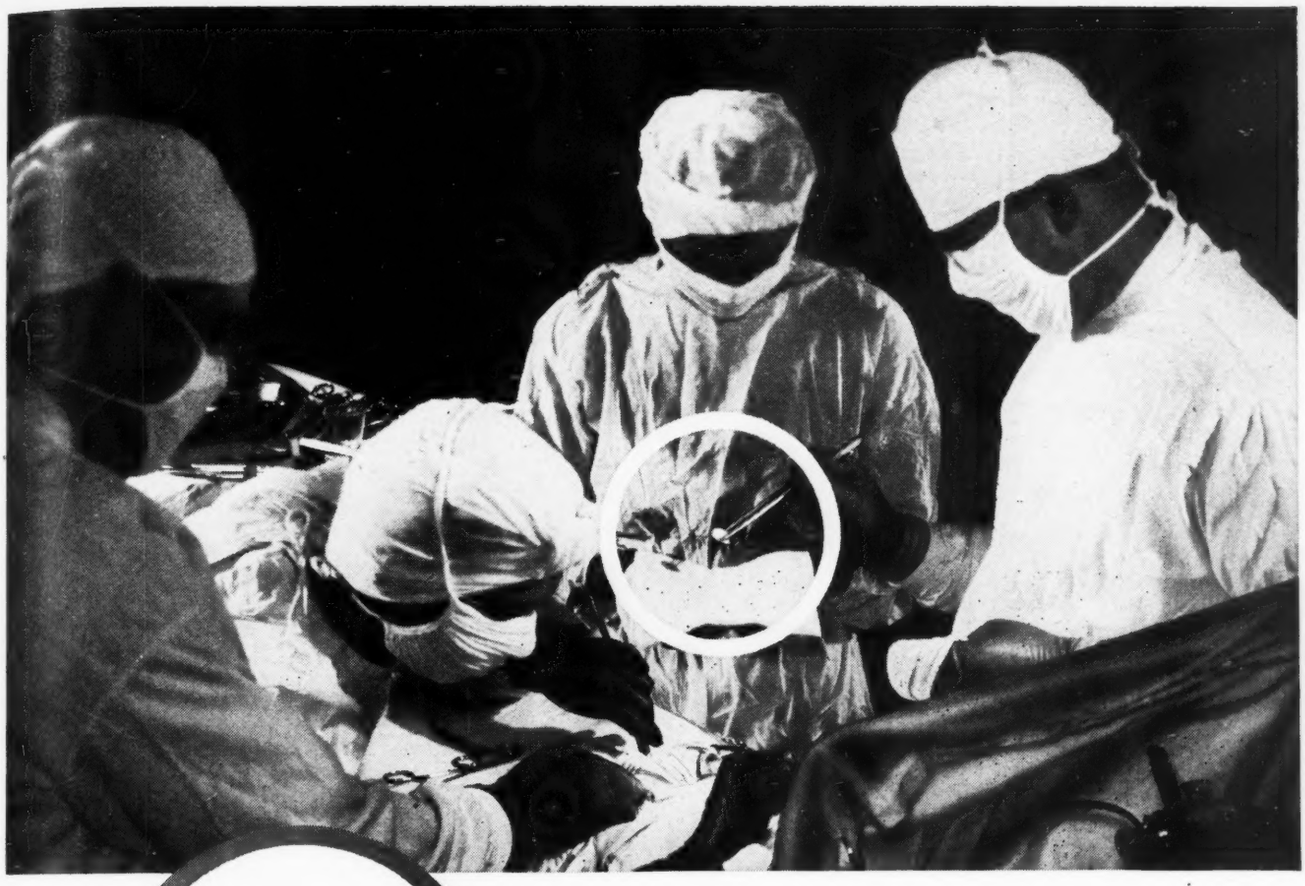
3. Block anesthesia refers to the direct introduction of the anesthetic onto a nerve trunk supplying the operative area. This may be a small peripheral nerve, such as the mandibular, or may include the large nerves where they originate near the spinal cord. Special types of block anesthesia include: paravertebral

Recommended Dosage and Concentration for Local Anesthetics

LOCAL ANESTHETIC	SAFE TOTAL DOSE (MGM.) INFILTRATION RELATIVE TOXICITY	CONCENTRATION FOR INFILTRATION	TOPICAL CONCENTRATION	ANESTHETIC OF CHOICE IN	MAXIMUM DOSE FOR SPINAL ANESTHESIA (MGM.)	MAXIMUM CONCENTRATION	DURATION (HOURS)
Procaine HCl	1000	0.5-1.0%	10%	Traumatized Urethra	200	5%	1—
Intracaine HCl	750?	0.5-1.0%	4%	Larynx, Nose and Throat	?	?	?
Metycaine HCl	750	0.5-1.0%	2%	Eye	150	5%	1+
			4%	Larynx(?), Nose and Throat, Urethra(?)			
Cocaine HCl	100	Never!	0.5-1.0%	Eye(?)	Never!	....	....
			5%	Nose and Throat, Larynx(?)			
Butyn Sulfate	75	Never!	2%	Eye	Never!	....	....
Tetracaine HCl	50	1:1000	0.5%	Eye			
		0.1%	1.0%	Larynx(?), Nose and Throat	15-20	0.5%?	1½-2
		(produces edema)					
Nupercaine HCl	25	0.05%	0.1%	Eye			
		1:2000	0.1-1.0%	Larynx, Hemorrhoids, Pruritis	6-12	0.1%	3-4

Use barbiturates as prophylactics against convulsions. (a) Barbital 0.5 Gm. night before surgery.
Phenobarbital 0.2 Gm. night before surgery.
(b) Pentobarbital 0.2 Gm. 2 hours before surgery.

If possible, always taste the anesthetic solution.
Use epinephrine (1:100,000) to prolong infiltration anesthetic effect except in surgery of hands and feet and in hyperthyroid patients.
Instruct the hospital nursing staff "Never supply cocaine in a syringe."
Use 1:1000 dilutions of the irritant anesthetics, tetracaine and nupercaine, for infiltration or spinal.
Remember that the specific gravity of cerebrospinal fluid is 1.005, which is equivalent to the specific gravity of 2.5 procaine in distilled water.
Consider the position of the spinal canal when using hypobaric and hyperbaric solutions.



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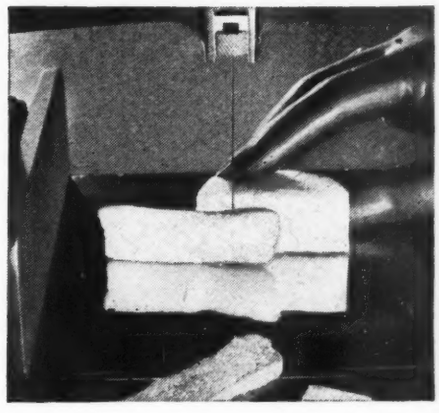

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block, spinal anestnesia, epidural anesthesia, transsacral block and caudal anesthesia.

Local Anesthetics in General Use

These will be considered in two groups: those which penetrate the mucous membranes and are used topically and those which are injected. Cocaine, butacaine, nupercaine, pontocaine and metycaine belong to the first group. Cocaine, from the leaves of Erythroxylon coca, a tree found in South America, is an ester of benzoic acid and a nitrogen-containing base, ecgonine.

Its pharmacological properties are those common to all local anesthetics. In addition, a direct effect on the cerebral cortex causing euphoric excitement, pleasurable hallucinations and feelings of great muscular and mental strength is frequently seen. For these reasons cocaine is sometimes taken by addicts who may develop psychic habituation but less physiological dependence than the morphine addict has.

Unlike the synthetics, cocaine applied locally produces vasoconstriction through direct action on the blood vessels; therefore, it is not necessary to combine epinephrine with cocaine. Cocaine has the desirable property of penetrating the mucous membranes, thus coming into direct contact with the nerve endings. Formerly cocaine was the chief agent used to anesthetize the cornea of the eye. However, its disadvantages now outweigh its advantages. Mydriasis, pitting of the cornea, sensitization of the sympathetic nervous system and local irritation are the usual toxic reactions.

Because of these deleterious properties of cocaine, attention has been focused on the development of more suitable synthetic substitutes. However, cocaine is still used as a reference standard for determining the potency of local anesthetics on the intact mucous membranes. In general, the synthetics have no addiction liability and are less irritating. One of these is butacaine sulfate U.S.P. (butyn sulfate). Since this local anesthetic is as toxic as cocaine and its anesthetic potency is the same, it is never injected. Butyn is less injurious to the cornea and produces rapid and prolonged anesthesia. Thus, it has largely replaced cocaine as an anesthetic agent for use in the eye.

Both tetracaine (pontocaine) and nupercaine effectively penetrate mucous membranes in low concentrations, although the onset of anesthesia with nupercaine is somewhat slower than that with the use of butyn or pontocaine. Both are from five to 10 times more toxic than cocaine when injected. Metycaine will also anesthetize mucous membranes in a 4 per cent solution. However, the other anesthetics previously mentioned are more potent and are used more frequently.

Infiltration Anesthetics

These include procaine HCl, intracaine HCl and metycaine HCl. Epinephrine 1:100,000 or 1:200,000 is used with all of these to prolong anesthesia and prevent absorption. Procaine is from one fourth to one sixth as toxic as cocaine after intravenous and subcutaneous injections. It is destroyed much more rapidly in the body and is nonirritating to tissues in a 2 per cent solution. One half of the original dose can be repeated in twenty minutes without causing convulsions. Its poor penetrating power makes its application to intact mucous membranes imprac-

tical, but for injection it is the least toxic of all local anesthetics. Because of its low toxicity it can be safely used to anesthetize traumatized mucous membranes where the use of more toxic agents might result in systemic reactions. Procaine is also used as the standard for infiltration anesthetics and is the drug of choice for routine spinal anesthesia.

Intracaine and metycaine are both slightly more toxic than procaine but slightly more effective. Both are non-irritating to tissues when used in anesthetic concentrations of 0.5 per cent to 1.0 per cent. Both produce a slightly longer duration of action than does procaine.

Spinal Anesthesia

This is a special type of extensive nerve block anesthesia. The anesthetic is usually injected into the subarachnoid space at the level of the second or third lumbar interspace, thus blocking the nerve roots as they emerge from the cord. This is a relatively safe procedure because the spinal cord does not extend below the first lumbar vertebra. Five anesthetic agents are used for this purpose. In the order of safety they are: procaine, metycaine, intracaine, pontocaine and nupercaine. In order to be effective for abdominal operations the anesthetic must pass upward to reach the nerve roots supplying the operative field. The height to which the anesthetic travels in the subdural space is governed by several factors:

1. Diffusion currents in the subarachnoid space.

2. Volume of fluid introduced and the strength of the solution. Quite frequently the agent is dissolved in cerebral spinal fluid previously removed. Two cc. of the solution will produce anesthesia only locally at the site of injection. Five to 10 cc. will affect nerve roots as high as the sixth thoracic.

3. Speed of injection. Fast injection will send the anesthetic higher, but a slow rate of injection is usually employed and the height of anesthesia is varied by other means.

4. Specific gravity of the solution. The specific gravity of the spinal fluid is 1.005. Solutions of nupercaine or pontocaine prepared with distilled water or with a small amount of alcohol have a specific gravity lower than this and are said to be hypobaric. Upward diffusion occurs with the patient in Fowler's position. Procaine in cerebrospinal fluid is hyperbaric and will settle downward. A high level of anesthesia is obtained with procaine by placing the patient in the Trendelenburg position. Five per cent glucose may be added to the more potent anesthetic agents to increase their specific gravity.

Spinal anesthesia usually becomes apparent from 2 to 6 minutes after injection. There is loss of sensation in the lower trunk followed by loss of sympathetic tone and loss of muscular tone. The blood pressure of the average patient falls about 36 per cent owing to loss of vasoconstrictor tone. Preanesthetic medication with intramuscular injections of ephedrine 50 mgm. reduces the fall to 14 per cent; methedrine, 20 to 30 mgm. to 3 per cent.

Spinal Anesthesia Complications

Inflammation of the cord and transient or permanent paralysis are the most serious complications. The mortality is high in comparison to other anesthetics, ranging from one death in 500 to one in 10,000. The morbidity depends a great deal upon the skill of the anesthetist and the condition of the patient, many of

whom are poor surgical risks. Spinal anesthesia should not be used in children, nervous individuals, hypertensive or hypotensive patients, elderly persons or those with central nervous system disorders.

Prevention of Fatal Errors

The A.M.A. recommends that:

1. Cocaine and butyn be used for surface anesthesia only.
2. The total amount of cocaine used be not over 0.1 gram.
3. Procaine as an injection anesthetic be used in a 0.5 to 1 per cent concentration.
4. No injection be made into the urethra if there is trauma, inflammation or stricture.
5. The spoken words "cocaine" and "procaine" should not be confused.

It should also be remembered that (1) the dose of all drugs is not one ampule; (2) the patient should be questioned about his sensitivity to the drug; (3) the solution should be smelled and tasted; (4) ampules should be stored in alcohol colored with methylene blue. — ELIZABETH H. JENNEY.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

The Sanitary Engineer

The modern sanitary engineer must consider political philosophy, a financial program, administrative structure and public education. Technology alone will not bring on the rapid correction of insanitation. This is the thesis developed by Abel Wolman, former president of the American Public Health Association, in an address, "The Sanitary Engineer Looks Forward," published in the November 1946 issue of the *American Journal of Public Health*.

One of the most important duties of the "statesmen in sanitation" is to transmit the abundant knowledge of sanitation technics of the Western world to those parts of the world which are not so fortunate. Timing, finance, social organization and public persuasion constitute the essential differences throughout the world. These differences, however, are not limited by geographical and political boundaries. Each one must be met on its own ground within the framework of its particular geographical and political setting.

Diseases that cause staggering death rates in India and China are often referred to as "tropical diseases." This is not true. The same diseases, at one time, were prevalent in Western Europe and America, but have been controlled through the diligent efforts of sanitary engineers. Diseases subject to control by this engineer will be the most important of health problems, and environmental sanitation will continue to be the greatest source of accomplishment in the reduction of morbidity and mortality.

The future functions of the sanitary engineer in the fields of water supply, sewerage, air control, housing, insect and rodent control remain essentially the same as in the past. It is vital, however, to expand the horizon of these functions, enlarge the geographical areas and maintain constant vigilance where a job has been done.

Furthermore, the sanitary engineer must become familiar with technics of financing in the cheapest and best manner possible in order to speed up activity. He must also develop an administrative structure that will execute his plans. However, in both financing and administration, he must work within the framework of the country in which he is located. The engineer must set and follow standards, prepare curriculums of education and develop a research program.—IRVING GOTTSEGEN.

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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Let's Plan Menus

DORIS ANN BOYLE
Assistant Chief, Dietetic Division
Veterans Administration
Branch Office No. 6, Columbus, Ohio

SUMMER is the time when a wilted attitude toward food needs the stimulus of dishes full of taste teasers garnished with eye appeal! Many of our eating experiences are comparisons, favorable or unfavorable. One may be reminded of a happy experience: you are taking a long journey and have been driving for many miles. It is almost mealtime and you have planned to stop at that famous old Southern inn for dinner. Immediately, you recall your last meal there—the delicious Southern fried chicken, country ham, corn pudding, hot biscuits and all the other delicacies that make for a delightful meal. The mere memory of such occasions makes your mouth water. After all isn't that "flavor"?

During the past few years we have been so busy with the difficult job of purchasing food of limited variety, and even doing much of the preparation ourselves, that we have lost sight of many of the niceties of food service. Now that labor is more plentiful and of a higher caliber, we must do a job, the kind of a job that we, as dietitians, want to do.

I should like to suggest some of the little personal touches that lift food from the "just ordinary" class into that of meals described as pleasant memories or happy experiences. Let us start with the first course. What is more tempting than a chilled appetizer on a hot day? The important thing about all appetizers is their flavor, which should always strive to sharpen the appetite but never to satisfy it.

Some of the following combinations may have greater appeal than do the juices of individual fruits:

1. Grapefruit, pineapple and lemon juice
2. Cranberry juice with gingerale
3. Apricot, grapefruit and orange juice
4. Cranberry, apricot and orange juice
5. Cherry and apple juice
6. Cranberry and apple juice
7. Prune and fresh lime juice

Another popular first course is a combination of juice with an appetizer, such as:

1. Tomato juice with watercress and cream cheese crescent
2. Pineapple and grapefruit juice with deviled ham and cheese spread on crackers
3. Vegetable juice cocktail with shrimp mixture on toast points
4. Fruit punch and toasted cheese pinwheel
5. Tomato juice with cream cheese and sliced olive on crackers
6. Sauerkraut and tomato juice cocktail with ground ham and horseradish on white bread circles.

You may want to use one of the following as an individual appetizer:

1. Anchovy Eggs

From the halves of hard cooked eggs, remove the yolks and mash them with anchovy paste. Put the mixture back in the egg whites and decorate with pimiento. Serve with quartered peeled tomato or crisp watercress. You may use ham salad as the filling also. (This would be ideal for a Sunday dinner or special occasion.)

2. Stuffed Tomato Appetizer

Select medium small tomatoes. Peel and scoop out the inside. Marinate in French dressing for one hour. When ready to serve, drain and fill with any of the following mixtures: tuna with celery; salmon, celery and chopped pickle; chopped eggs with ham or crabflakes with celery and thinned mayonnaise.

3. Stuffed Cucumbers

Peel medium sized cucumbers and slice in half inch slices. Place in ice water with salt and vinegar for thirty minutes. Drain, dry and hollow out each piece. The center may then be filled with a variety of fillings, such as: egg yolk with anchovy paste; salmon with finely chopped celery; chopped egg seasoned with mustard and Worcestershire sauce with tiny strips of pimiento across top, or cream cheese and onion mixtures. Serve on a bed of crisp watercress.

On the other hand, you may choose to serve relish trays of assorted appetizers, such as:

1. Celery stuffed with blue cheese
2. Celery stuffed with pimiento cheese
3. Celery stuffed with cream cheese and finely diced cucumber
4. Radish roses
5. Carrot sticks
6. Cottage cheese with chives (served in glass dish in center of tray)
7. Spiced peaches
8. Spiced pears
9. Spiced watermelon pickles
10. Small gherkin pickles wrapped in smoked salmon

The field of appetizers is unlimited. Just a bit of imagination will make a relish plate that is not only extremely tempting but decorative as well. These extra touches bring us out of our humdrum existence.

Fruit cups offer infinite variety, depending upon the fruits available and your artistic sense.

1. Fresh strawberries and grapefruit sections
2. Fresh pear slices in orange juice with blackberry garnish
3. Pineapple cubes, orange sections and candied ginger
4. Fresh peach cubes, sliced banana with red raspberry garnish
5. Orange sections and juice with chopped mint leaves and pomegranate seeds
6. Fresh pineapple and strawberries

Appetizer salads are becoming quite popular. They should be small and have a sharp, light dressing:

1. Sliced orange on watercress with fresh dressing
2. Grapefruit sections and sliced strawberries on chicory with fresh lime juice dressing
3. Sections of oranges and grapefruit served on a glass plate surrounded with chopped fresh mint

A natural

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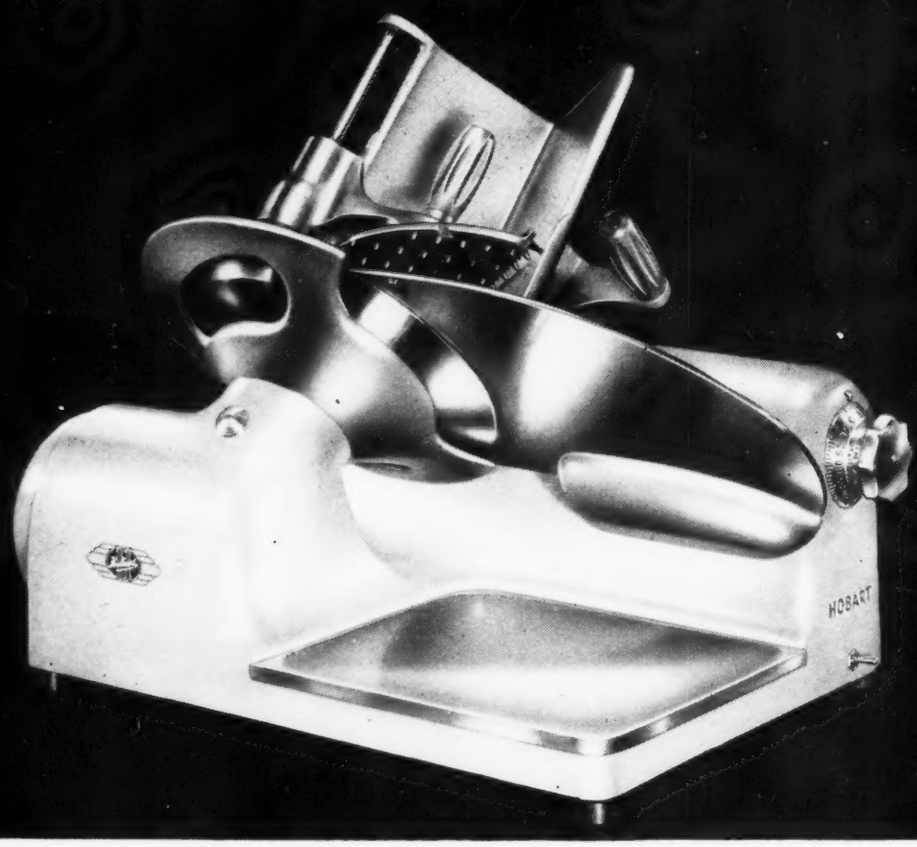

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4. Sliced tomatoes on watercress with anchovy fresh dressing
5. Grapefruit sections, alternating with slices of avocado and chili sauce and French dressing with diced celery
6. Coleslaw (very tangy on a slice of tomato with watercress garnish)

Seafood cocktails are nearly always popular. They should be served cold. The usual sauce served with sea food is made of chili sauce or catchup, with the addition of lemon juice, Worcestershire and a dash of Tabasco. Some people enjoy a sauce with added horseradish, chopped pickle or finely chopped celery.

Flavor is of extreme importance. Flavor in food, in most cases, is a combination of flavors as perceived by the sense of taste. Aroma is accorded by the sense of smell, such as the aroma of steaming hot coffee. Texture is exemplified by the smoothness of an avocado or the crunchiness of crisp celery. The sense of sight is important, too. We derive much pleasure from seeing food served attractively and in a colorful manner.

The four primary tastes are sweet, salty, sour and bitter. Most foods are a combination of two or more, for example, peaches have a sweet, sour and bitter taste, blended into what we call peach flavor.

Ripening and refrigeration add much to the flavor of fruits and vegetables. From then on the care used in handling and preparation has much to do with the pleasure of eating and the preservation of nutrients.

Temperature Is Important

We all know that if cut fruits and vegetables are exposed to the air their flavor will be partially destroyed. They also taste better if eaten within a reasonable time after they are harvested. Temperature is important, too. Chilled fruits are usually best, but it is possible to have fruits so cold that they are tasteless. A good example of the difference in flavor caused by incorrect temperature can be experienced by comparing the flavor of a slightly warm baked apple with that of one which has been stored in a refrigerator for hours.

Fruits that require sugar need a certain amount of time to develop their flavor. Strawberries for shortcake should be cut, not mashed; sugar should be added to them, and they should be allowed to stand for one hour. If they stand too long, however, their flavor and color deteriorate. Fresh rhubarb, on the other hand, has a smoother flavor if it is baked with sugar and a little water in a covered dish, just until tender, and left to cool in the same dish for several hours before serving.

Lemon juice and salt bring out the flavor of many fruits, such as melons and pears. Combinations of fruits are often tastier, especially if one is rather bland.

The flavor of meat is changed with variations in the method of preparation and length of cooking time. The characteristic flavor of beef, for example, is much more pronounced in fat than in lean meat, and rare roast beef differs in flavor from well done beef. Temperature plays a large part in the enjoyment of meat. That is one reason why we serve pickles and relishes with cold meats and poultry.

Many interesting flavors can be developed by the use of herbs and spices properly blended. The blending of several herbs, rather than the use of a large amount of one is good practice. They should be used in such proportions that no one flavor predominates.

In cooking vegetables, salt helps to bring out flavor. Certain other combinations are inseparable, too. A bit of sugar with tomatoes is a "must" in some sections. A suggestion of lemon or onion, or a touch of garlic, is used to "step up" other flavors.

Some good uses for other herbs include: marjoram in practically all meat dishes, especially chicken and veal; rosemary with green beans; sage in stuffings for meat, dressing and sausages; savory in meats and with beans; tarragon with fish and egg dishes, and thyme with fish and meats.

Onions are delightful to use as a flavoring, but they should be used with caution and in the proper way. When onions are added in slices or chunks they have a harsh, unpleasant flavor, so it is better to sauté them before adding them to bread dressing. If only a slight onion flavor is desired a few drops of onion juice may be added. A bit of garlic rubbed on the side of a bowl in which food is to be mixed or a cut clove of garlic rubbed on the inside of duck or on

MENU SUGGESTIONS

Orange and grape juice
Broiled flank steak
French fried potatoes
Small young carrots with chopped watercress
Mixed green salad with clear French dressing
Strawberry shortcake

Apricot and grapefruit juice
Baked ham
New potatoes with peas in cream
Lettuce and spinach salad with egg in French dressing
Fresh plum upside-down cake

Hot vegetable bouillon
Breast of lamb barbecue
Fluffy mashed potatoes
Fresh spinach with lemon
Peach, pineapple, banana and strawberry salad
Vanilla ice cream

Lentil soup
Eggs Benedict (English muffin)
Idaho baked potatoes
Fresh Asparagus
Hot green apple pie

Spanish chowder
Veal baked in sour cream
New parslied potatoes
New beets with greens
Celery hearts Olives Radishes
Peach cobbler

Strawberry and fresh pineapple cup
Baked ham with glacéed pineapple
Sweet potato puff
Fresh buttered asparagus
Spiced cantaloupe Pickle on lettuce
Lemon chiffon pie

Cream of onion soup
Broiled mackerel paprika
Boiled new potatoes
Buttered kale
Carrot and cabbage slaw
Fresh rhubarb and strawberry pie

Grapefruit and strawberry cup
Broiled sweetbreads on toast with fresh mushroom sauce
Delmonico potatoes
New green beans
Sliced tomato
Snowball cake with hot fudge sauce

(Other menus by Miss Boyle will appear in a subsequent issue.)

leg of lamb will improve the flavor of both.

Sherry flavoring used in cooking gives certain foods a subtle, elusive flavor, *i.e.* sherry flavoring in lobster thermidor. After the sherry flavoring is added, the food should not be allowed to reach the boiling point.

Spices and extracts should always be of the best quality. It is false economy to use poor seasonings and thereby spoil a good product.

Especially Suited to Summer

ESSIE L. ELLIOTT
Director of Home Economics
California Fruit Growers Exchange
Los Angeles

WHY can't food taste as good here as it does at home?" is a frequent query of a hospital patient.

"Why can't I have a cool fruit salad and a sandwich or rolls instead of meat, mashed potato, string beans and limp lettuce with cottage cheese on it?" asks another.

"What's the idea? No *hot* food today?" says a third patient. "Salads aren't enough for *me*."

Why is a patient so critical of the tray served to him in the hospital? There, food takes on an exaggerated importance. Breakfast, lunch and dinner break the monotony of his day. They furnish a kind of surprise to look forward to, a pleasant one if the food looks appetizing and tastes wonderful.

However, disappointments can hardly be avoided. The fickle appetite of the hospital patient is difficult to satisfy. The dietitian's only hope is that by careful planning, marketing and supervised preparation, by efficient and well timed service, the food will reach the patient looking and tasting the way she would want it served to herself.

The best food does not always taste good to one who is ill, but if it looks appealing the patient is more likely to blame himself than the dietitian for his lack of appetite.

In summer the feeding of the hospital patient presents some problems quite different from those encountered in cold weather.

The physicians, the nurses, the dietitians, the staff in the kitchen, too, all react to hot sultry days by wishing for food and beverages which suggest the coolness they long for.

This is the season when the dietitian calls to her aid all the clever tricks she knows for making food especially appetizing. Her ingenuity in planning menus for general, light, soft, liquid or special diets is taxed to the utmost. Hospital patients tend to be emotionally as well as physically disturbed in any season, but summer heat makes them doubly hard to please.

A recent survey of leading hospitals in various states resulted in several helpful suggestions, as well as a clearer understanding of problems confronting the staff responsible for the food. A few of these suggestions for general diets are given.

Salads contribute coolness, freshness and special health values. They are now so much a part of the well person's diet that dietitians are paying more attention than ever to their value in tempting the appetites of patients.

Side Salads

Individual gelatin mold (any color or flavor) with one avocado ball and four red berries in each.

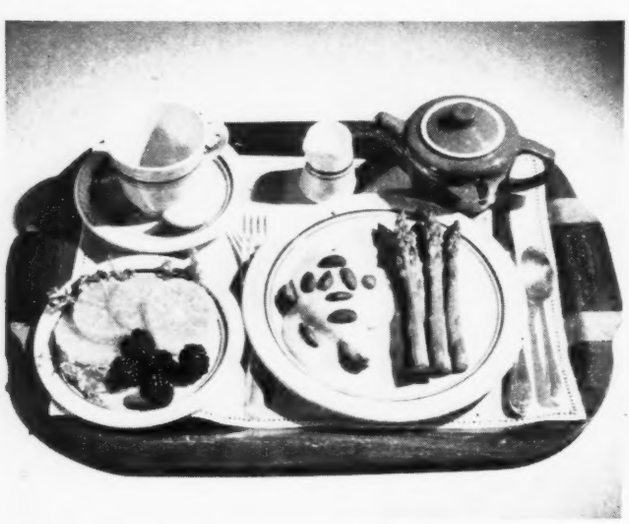
Fresh peach half (dipped in lemon or orange juice to prevent darkening), cottage cheese in center, one fresh berry for color accent.

Four or five orange slices, strawberry slices or avocado on crisp romaine.

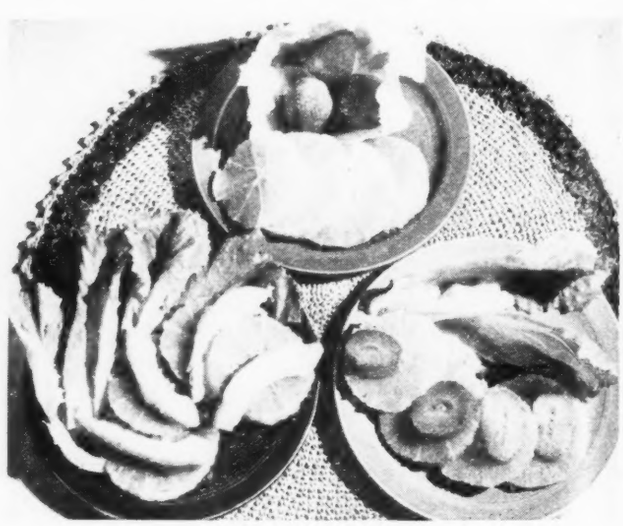
Shredded carrots, cottage cheese and pineapple tidbits.

Golden salad—shredded carrots in orange gelatin mold plus fruit in season.

Fresh pear half centered with cream cheese ball rolled in parsley.



This attractive tray is a time and labor saver, too. Toasted salted almonds add a new flavor to buttered fresh asparagus served with cheese rarebit on toast.



Three appetizing side salads: orange and avocado on romaine; orange slices, fresh strawberries in lettuce cup; orange and strawberry slices served with romaine.

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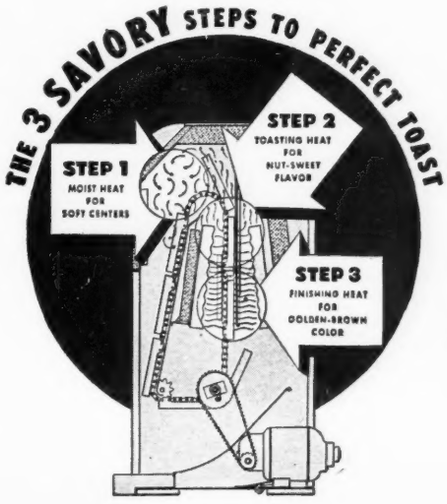

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For variation, marinate the pear halves in green minted sirup and roll the cheese ball in chopped maraschino cherries.

Avocado half or quarter with lemon and salt for dressing. Watercress garnish.

Canned cling peach or fresh peach half, filled with raspberries.

Summer Supper Plate

Chicken broth
Sliced tomatoes *Carrot sticks*
Watercress
Baked potato
Creamed dried beef
Whole wheat bread and butter
Gingerbread with lemon sauce
Milk or tea
Beef broth

Orange sections and berries
Cheese rarebit on toast
Asparagus tips
Muffins and butter
Pound cake (plain or toasted) topped with ice cream and crushed pineapple
Beverage

Salad Fruit Plate

Arrange any three, four or five of the following fruits on a dinnerplate. Accompany with cheese biscuits, a beverage and a dessert, such as rice pudding or caramel custard:

Mixed melon balls or cubes
Banana cuts rolled in fruit juice and then in graham cracker crumbs
Seedless grapes
Berries in season
Orange slices or sections
Fresh pear slices
Fresh peach halves

Salad Dressings

Have a variety of well refrigerated salad dressings always on hand. Use a different one for each meal unless the patient demands otherwise.

Fruit dressings are favored by many who react against oil when appetites are jaded by illness or emotion. The simplest fruit dressing is fruit juice. If an extremely tart juice is at hand, combine with sugar or corn sirup to taste.

For a thickened fruit dressing, mix fruit juices with sugar and cornstarch and cook to desired consistency. Chill.

Delicious Lemon Mayonnaise

4 eggs
¼ cup sugar
3 tbsp. salt
1½ tbsp. dry mustard
¼ tsp. pepper
1 cup lemon juice
1 gal. salad oil

Beat eggs in electric mixer until light, about three minutes Mix sugar and spices together and sift. Add two tablespoons of the lemon juice and all the spice and sugar mix to the eggs. Begin to add salad oil very slowly and continue beating. When oil is completely blended add remainder of lemon juice.

(*Yield: approximately 1 gallon*)

Lemon Lorenzo Dressing

1 qt. French dressing (made with lemon juice)
1 cup chopped watercress
½ cup chili sauce

Blend well. Serve on lettuce or other salad green. Excellent on vegetable or meat salads.

Sherbets make excellent fruit salad dressings and toppings. A ball of lemon, orange or pineapple sherbet on a bowl of fruit salad is most refreshing and appetizing.

Summer Desserts

Ice cream with sweetened crushed fresh fruit as topping
Melon half topped with sherbet
Fruit cup. With sherbet topping and mint sprig, it is an extra special dessert
Lemon meringue pie
Fresh fruit shortcake with ice cream or whipped cream on top
Gingerbread with fruit or custard sauce
Ambrosia (orange slices and fresh frozen coconut)
Rice pudding, gelatin garnish
Soft custard with orange sections
Banana fritters with orange or lemon sauce. (Recondition bacon fat for deep fat frying by boiling it in water to remove smoky taste.)
Orange tapioca
Lemon cake top pudding

Hot Day Dessert

Small bowl of crushed ice heaped to "mountain" height. Insert fresh fruit or impale on toothpicks. Examples: fresh strawberries, wedges of fresh or canned pineapple, orange sections or wedges, grapes, plums, cantaloupe cubes.

Remove every other section of a halved grapefruit. Insert berries or red or green gelatin in empty spaces. Serve chilled. (Use removed sections for fruit cups.)

Beverages as Morale Lifters

A beverage in midmorning, midafternoon or late evening is a most welcome break in those tedious hours between meals.

Some suggestions for beverages of the surprise type follow.

Floats of sherbet or ice cream on fruit juice
Crushed pineapple in orange juice
Orange banana shake
Lemonade with papaya or passion flower juice
Fresh grapefruit and orange juice with berries

The Little Touch That Counts So Much

To save sugar and to hold flavor, dip small fruits in hot sugar sirup and chill before serving.

Put that berry or other garnish on just as trays go out.

Watch for contrasts as much as possible—color contrasts, flavor contrasts—something soft and something crunchy (toasted almonds on creamed chicken, for example).

Buy small amounts of the first foods on the market, such as strawberries, asparagus, cherries and other just-in-season items, even though they are costly. A small portion on the tray or as a garnish will do much to please the patient and give him something to brag about when he talks of *his* hospital and its food.

Give the finicky patient, to whom an entire meal on the one tray is appalling, something special from the diet kitchen—an omelet with a bit of jelly and crisp toast—and reap dividends of good will for the hospital.

The Dietitian's Dream

Have food reach the patient as hot as the hot foods should be and as cold as the cold foods should be.

Find assistants who know good food and who are willing to prepare it according to the dietitian's directions so that the hospital may demand and maintain high standards of service.

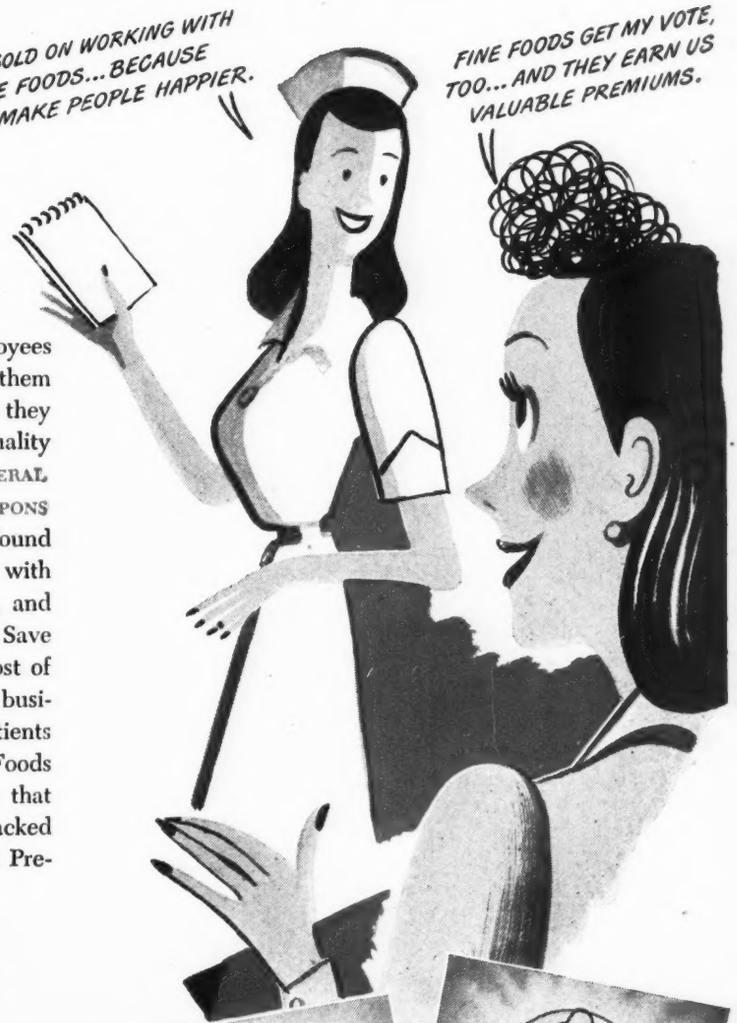
Find cooks who are willing to try new ideas and recipes that the dietitian may propose.

Be able to use recipes, food combinations and garnishes in a 500 bed hospital with as successful results as are obtained in a 20 bed hospital.

If such dreams come true, it will be because the dietitian has an administrator who understands her problems and who cooperates with her in keeping the growth of the kitchen in step with the growth of the hospital.

When the dietitian's dreams come true, the hospital's prestige will rise as will the morale of everyone, doctors, nurses, employes and patients.

DOES *TALK* WORK FOR YOU?



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Menus for September 1947

Florence Topoleski
Mary Lane Hospital
Ware, Mass.

1
Tokay Grapes
Soft Eggs
•
Apple Juice
Roast Chicken
Candied Sweet Potatoes
Buttered Beets
Chocolate Nut Sundae
Nuts and Mints
•
Asparagus Soup
Hot Roast Lamb
Sandwich With Gravy
Pineapple and Cream
Cheese Salad
Marble Cake

2
Oranges
Poached Eggs
•
Hamburger Patties
Baked Potatoes
Cauliflower With
Cheese Sauce
Carrot Strips
Pineapple Upside-Down
Cake With Whipped Cream
•
Tomato Soup
Broiled Sweetbreads
With Bacon
Buttered Rice
Applesauce
Sugar Cookies

3
Grapefruit Juice
Scrambled Eggs
•
Tomato Juice
Roast Veal
Mashed Potatoes
Buttered String Beans
Grilled Tomatoes
Celery Hearts
Lime Sherbet
•
Chef's Soup
Welsh Rarebit With
Shrimps on Toasted
Saltines
Molded Fruit Salad
White Cake With Cherry
Frosting

4
Orange Juice
Soft Eggs
•
Vegetable Juice
Roast Lamb With
Mint Jelly
Parsley Potatoes
Buttered Carrots
Snow Pudding With
Soft Custard Sauce
•
Tomato Soup
Grilled Pressed Ham
Baked Potatoes
Waldorf Salad
Chocolate Cake With
White Frosting

5
Pineapple Juice
Poached Eggs
•
Tomato Juice
Baked Fillet Fish,
Tartare Sauce
Baked Potatoes
Yellow Squash
Green Mixed Salad
Strawberry Ice Cream
•
Alphabet Consomme
Oyster Casserole
Beet Salad
Gingerbread With
Whipped Cream

6
Prunes
Scrambled Eggs
•
Grapefruit Juice
Veal Birds With Tomato
Sauce
Mashed Potatoes
Peas
Rice and Raisin Pudding
•
Vegetable Soup
Bacon
Escalloped Potatoes
Fruit Salad With Cream
Cheese Topping
Vanilla Cookies

7
Grapefruit
Scrambled Eggs, Bacon
•
Fruit Cup
Baked Ham
Mashed Potatoes
Buttered Beets
Celery, Olives
Chocolate Ice Cream
•
Asparagus Soup
Tuna Salad
Sliced Tomatoes
Potato Chips
Orange Gelatin With
Whipped Cream

8
Blended Fruit Juice
Soft Eggs
•
Lamb Chops
Baked Potatoes
Buttered Broccoli
Butterscotch Pudding With
Whipped Cream and Nuts
•
Beef Broth
Spaghetti With Meat
Sauce
Mixed Green Salad
Pineapple
Chocolate Cookies

9
Tomato Juice
Poached Eggs
•
Roast Beef
Mashed Potatoes
Baked Acorn Squash
Stuffed Celery
Raisin Puff With Orange
Sauce
•
Chef's Soup
Bunnies With Cheese
Sauce
Tomato Salad
Peaches
Sugar Cookies

10
Stewed Apricots
Scrambled Eggs
•
Vegetable Juice
Liver With Bacon
Parsley Potatoes
Buttered String Beans
Peach Ice Cream
•
Chicken Broth
Creamed Mushrooms With
Split Baked Potatoes
Carrot and Raisin Salad
Sliced Bananas
Orange Cookies

11
Apple Juice
Soft Eggs
•
Fruit Cup
Beef and Vegetable Stew
en Casserole With Biscuits
Coleslaw
Raspberry Gelatin With
Whipped Cream
•
Tomato Soup
Baked Tuna Loaf
Hot Peas
Mixed Green Salad
Blue Plums
Marble Cake

12
Grapefruit Juice
Poached Eggs
•
Tomato Juice
Codfish Cakes
Buttered Peas
Buttered Carrots
Orange-Pineapple Ice
Cream
•
Mushroom Soup
Baked Cheese Sandwich
Banana and Cherry Salad
Oatmeal Cookies

13
Prune Juice
Scrambled Eggs
•
Broiled Beef Steak
Mashed Potatoes
Buttered Brussels Sprouts
Deep Apple Pie
•
Vegetable Soup
Bacon
Spanish Rice
Lettuce Wedge Salad
Grapes
Sponge Cake

14
Applesauce
Egg Nest
•
Fruit Cup
Roast Turkey With
Dressing
Cranberry Sauce
Mashed Potatoes
Fresh Peas
Celery, Olives
Pineapple Sundae
•
Tomato Soup
Egg Salad With
Sliced Tomatoes and
Pickles
Baked Potatoes
Pears
Cookies

15
Orange Juice
Scrambled Eggs
•
Vegetable Juice
Roast Veal
Oven Browned Potatoes
Buttered Spinach
Rice and Pineapple
Pudding
•
Chicken Broth
Baked Cheese Souffle
Tomato Tulip Salad
Baked Apple With
Whipped Cream
Ginger Cookies

16
Pineapple Juice
Soft Eggs
•
Hamburger Patties
Mashed Potatoes
Buttered String Beans
Tomato Aspic Salad
Lemon Meringue Pie
•
Asparagus Soup
Chicken and Vegetable
Pie en Casserole
Coleslaw
Mixed Stewed Fruit
Butter Cookies

17
Prunes
Poached Eggs
•
Corned Beef
Parsley Potatoes
Buttered Carrots
Buttered Beets
Mustard Pickle
Maple Walnut Ice Cream
•
Vegetable Soup
Bacon
Baked Macaroni With
Cheese
Mixed Green Salad
Stewed Apricots
Peanut Butter Cookies

18
Blended Fruit Juices
Scrambled Eggs
•
Swiss Steak
Baked Potatoes
Buttered Cauliflower
Stuffed Celery
Apple Betty With Hard
Sauce
•
Beef Broth
Baked Hash With
Creamed Peas
Fruit Salad
Macaroons

19
Apple Juice
Egg Nest
•
Grapefruit
Broiled Haddock,
Tartare Sauce
Baked Potatoes
Green Beans
Berry Pie
•
Clam Chowder
Molded Tomato Salad
With Mayonnaise
Peaches
Chocolate Cake

20
Sliced Orange
Omelet
•
Lamb Chops
Escalloped Potatoes
Buttered Carrots
Celery Hearts
Tapioca Pudding With
Whipped Cream
•
Cream of Spinach Soup
American Chop Suey
Mixed Green Salad
Rhubarb
Date-Nut Bars

21
Grapefruit
Scrambled Eggs, Bacon
•
Fruit Cup
Roast Beef
Parsley Potatoes
Buttered Peas
Celery, Olives
Maple Walnut Ice Cream
•
Chicken Broth
Potato Salad
Sliced Tomatoes
American Cheese
Grapes
Sugar Cookies

22
Apricot Nectar
Soft Eggs
•
Meat Loaf
Mashed Potatoes
Asparagus Tips
Lettuce With Russian
Dressing
Peach Cobbler
•
Mushroom Soup
Toasted Lettuce, Tomato
and Bacon Sandwiches
Fruit Gelatin
Walnut Cookies

23
Blended Fruit Juices
Poached Eggs
•
Pot Roast of Beef
Oven Browned Potatoes
Creamed Corn
Carrot Strips
Chocolate Fudge Cake
•
Tomato Soup
Cheese Fondue
Waldorf Salad
Ginger Cookies

24
Oranges
Omelet
•
Pineapple Juice
Baked Ham
Sweet Potatoes
Peas
Frozen Pudding
•
Chicken Soup
Stuffed Peppers With
Chili Sauce
Carrot and Raisin Salad
Lemon Layer Cake

25
Prunes
Soft Eggs
•
Chicken and Vegetable en
Casserole With Biscuits
Coleslaw
Tomato Quarters
Apricot Upside-Down Cake
With Whipped Cream
•
Corn Chowder
Asparagus on Toast
Perfection Salad
Vanilla Cookies

26
Sliced Bananas
Egg Nest
•
Grapefruit Juice
Baked Fillet Fish With
Dressing
Mashed Potatoes
Harvard Beets
Strawberry Ice Cream
•
Clam Chowder
Tuna Salad
French Fried Potatoes
Chocolate Pudding

27
Stewed Apricots
Poached Eggs
•
Lamb and Vegetable
Stew en Casserole With
Biscuits
Mixed Green Salad
Cherry Pie
•
Vegetable Soup
Ham Salad
Baked Potatoes
Peaches
Nut Cake

28
Grapefruit
Omelet
•
Tomato Juice
Roast Turkey
Mashed Potatoes
Buttered Broccoli
Olives, Celery
Frozen Pudding
•
Beef Broth
Baked Macaroni With
Cheese
Fruit Salad
Orange Layer Cake

29
Orange Juice
Scrambled Eggs
•
Roast Lamb, Mint Jelly
Escalloped Potatoes
Buttered Spinach
Gingerbread With
Whipped Cream
•
Tomato Soup
Cream Dried Beef in
Split Baked Potato
Asparagus Tips
Blue Plums
Cookies

30
Tomato Juice
Egg Nest
•
Broiled Beef Steak
Parsley Potatoes
Baked Acorn Squash
Coffee Bavarian Cream
•
Stuffed Celery
Baked Salmon Loaf
With Creamed Peas
Buttered Noodles
Peaches

Ready-to-eat or cooked cereals are offered on all breakfast menus.

PLANT OPERATION & MAINTENANCE

Prevention Is the Better Part of Maintenance

JAMES HUGHES
Chief Engineer, Eastern Maine General Hospital, Bangor, Maine

A STITCH in time saves six," Henry Morgan says, and his paraphrase is appropriate in discussing maintenance in these days of inflation. In the overall picture of institutional maintenance an important part of that famous stitch is lubrication. A properly planned and carried out lubrication program can be tied in with the checking and supervision that are necessary to eliminate excessive maintenance costs. What makes up this lubrication program? Let us divide it into four parts: type, time, records and personnel.

The greases and oils to be used on the many different pieces of equipment in an institution should be selected from those of a reputable manufacturer, and in that selection care should be taken to keep the number of types of lubrication to a minimum.

One Type for Many Needs

As an example, a type of grease can be obtained for temperatures to 390° F., and a motor bearing oil can be obtained for motors from fractional to 15 h.p. In the gear cases of many pieces of machinery the recommendations of the manufacturers on the viscosity of the oil will vary only 10 points. Often, the same gearing is made by different manufacturers and one gear case oil will be found to satisfy many requirements. With a controlled number of lubricants and a proper knowledge of what each will accomplish, it is much simpler to apply the one that will be best suited to the required job of preventing wear on a moving part.

Presented at the New England Hospital Assembly, 1947.

The time that should elapse between applications of the lubricant is another important factor. This is arrived at by a study of the individual piece of equipment to determine its lubrication characteristics and to learn how many and how hard are the tasks it performs and under what conditions. Then a definite schedule can be set up to take in each piece of equipment.

The necessity for keeping adequate records to coordinate the lubrication program deserves discussion at this point. A card system can be used to advantage, with each card containing the name and location of each piece of equipment, the type or types of lubricant to be used and the frequency. A column is provided to chart the date of each application, and other specific information can be entered on the card. As an example, in the case of an elevator, a separate notation that the gear case lubricant is changed and the gear case is flushed once a year can be entered. Now we come to the fourth and most important part of a well planned lubrication program: the person responsible for its being carried out. It is interesting to note that in many large plants having a definite job classification schedule for the advancement of the personnel, the "oiler," so called, is at the bottom of the list, the newest member of the crew. But when there is a great deal of expensive equipment to be cared for properly just any man with an oil can in one hand, a grease gun in the other and some waste stuffed into an overall pocket cannot do a proper job of lubrication.

A responsible, conscientious person will study the equipment in order that the right material, the right amount and the right timing will produce results. He will keep accurate records and check them faithfully at the start of each lubrication schedule, and he must be given ample time for his lubrication itinerary which, of course, depends upon the size of the institution.

With a satisfactory lubrication program set up and a responsible person carrying it out, a constant check can be made of all equipment that requires lubrication. To explain more fully, every motor, pump and fan, no matter where located, will be visited under a charted and planned itinerary.

Checks All Machinery

The actual greasing or oiling of the individual piece takes only a short time for a trained man, so he checks, to cite a few examples, the V-belts on a freon compressor, the alignment of a directly driven vacuum pump, the noisy contacts on the control board of an elevator, the filter on an air compressor, the air hose on the laundry presses, the specific gravity and the pH of the brine in an ice maker, the packing on a centrifugal boiler feed pump. He cannot and, of course, should not be expected to make all repairs at the time of lubrication, but he should be trained to observe needs and to get them on paper so that they will come to the attention of the department head.

If equipment records are maintained, the person responsible for lubrication should have access to them, should familiarize himself

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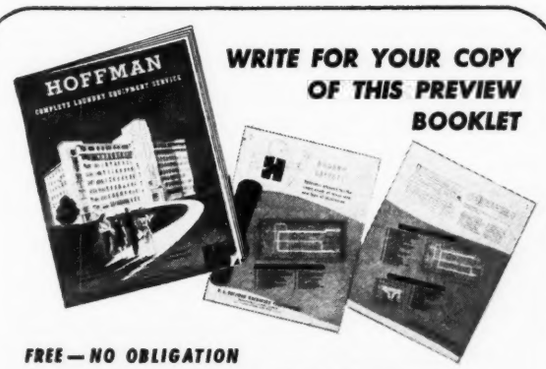

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with what has been done for each piece of equipment and wherein the chief trouble lies. Suppose a motor has had bearing trouble at regular intervals; the conscientious worker will watch that motor carefully to see if perhaps faulty lubrication is the cause. When new equipment is installed, the manufacturer's recommendations should be turned over to the lubrication man for study and for incorporation into his records.

While many of the preventive measures needed to keep excessive maintenance down can be tied into a good lubrication program, there is, however, much equipment that needs checking and supervision apart from the lubrication angle. For example, engineers who are responsible for steam generation in high pressure plants are well aware of the need for good feedwater treatment. A ruptured tube or a sagging crown sheet caused by excessive scaling or the element of corrosion in boilers and return lines will be costly on maintenance sheets and may even be costly in property damage and loss of life.

Adopt Good Feedwater Treatment

Manufacturers of feedwater treatments have come a long way in the services rendered to ensure good clean boilers. Represented by competent field engineers who take periodic samples of boiler water for laboratory analysis, manufacturers set up a system within the plant for tests, daily or at other fixed intervals. Faulty operation of steam traps has many times been corrected by the adoption of a good feedwater treatment.

As to the specialized equipment within an institution, routine checking and inspecting are also necessary to eliminate costly maintenance. On autoclaves, for instance, gaskets should be watched so that they can be changed before they become so grooved or so hard that further closing of the door will cause bent pressure bars which will then have to be replaced. Canopies of oxygen tents should be checked routinely, if possible after each use, for a slight tear can be mended whereas one more turn may result in destruction. It is good policy to check oxygen tents thoroughly after each use, for they must be in correct working order at all times. Motors on oxygen tents, although they require infrequent oiling, will be charted in a good system, as will even the wheels on all stretchers and trucks.

What about maintenance of the buildings themselves? Old Man Weather is our greatest enemy; damage caused by rain, snow and ice can be extremely costly. Inspection of caulking around window and door openings, in joints between brick and stone or granite and around brick pilasters and the application of dampproofing to stone trim and to masonry walls when necessary are highly important in the elimination of seepage. The periodic painting of wood or steel sash and the checking of the glazing on them are always incorporated into a good maintenance program. Planned roof inspections, especially on buildings of older construction, should be incorporated into the program.

As to interior maintenance, labor is the major expense in painting and the cost of the paint itself plays a small part in the overall maintenance expense. The increasing recognition of color therapy in hospital rooms and wards has resulted in the use of many pastel colors which require more frequent washings. Therefore, the quality of the paint should be of the highest grade or the time between paintings will be shortened and, consequently, higher costs will result.

For example, on the inspection of a four bed ward in preparation for a paint job, it is discovered that the plaster just above the baseboard is severely gouged. The mason is called in to patch this, or perhaps one of the painters will do it. The paint job follows. Cannot something be done to prevent a recurrence of this gouging which in a short time will spoil a good job? At a small cost, rubber bumpers can be installed on the shanks of the bed casters which will not mark the walls and which will prevent this gouging. This is a small item, to be sure, but one that adds to appearance and subtracts from unnecessary labor and materials.

Another important point in the overall picture of preventive maintenance, and one on which all maintenance engineers will agree, I am sure, is the purchase of equipment and the construction of buildings. "The first cost is the only cost" may be an exaggerated phrase, but it is worthy of consideration. The saving on the purchase of an inferior piece of equipment will soon disappear when constant repairs are necessary in order to keep the equipment in use.

Many times, the individual piece of equipment or machinery is well manufactured in every detail but in the fabrication a special part may be used which is made by a reputable concern but is not really intended for use with the item in question. It is used because it blends in with the equipment, the lines are beautiful, but the manufacturer of this special part is not familiar with the actual function of the equipment on which it will be used; and in such cases the maintenance man will discover the wrong application and will have to live with it!

It's the Engineer's Headache

Today's maintenance engineer is being consulted in the purchase of equipment and machinery a great deal oftener than was his predecessor; he should be, for once the equipment is installed it becomes his headache when maintenance becomes excessive. He, in turn, owes a responsibility to the institution to study the equipment and be able from experience to justify his reasons for selecting it; this applies particularly to specialized equipment.

In the construction of new buildings, if the maintenance engineer has the opportunity to consult with the architect occasionally he may be able to point out a number of small items that will eliminate unnecessary expense later, such as the placing of steel plates on projecting corners into which food trucks and porters' trucks will be pushed, the protection of corridor walls opposite elevators and, in the installation of plumbing fixtures, the use of trim that has renewable seats. To be a little more specific, if the steam valves of autoclaves and bedpan washers are equipped with renewable seats and disks a tight valve will be assured at all times with a minimum of labor and parts.

Much more might be said about preventive maintenance, but basically it can be divided into three parts: purchase of good equipment, proper and periodic inspection and care and education of those who use it to prevent abuse.

PIONEERING *again*

Certain names in industry have a distinguished reputation for superiority. They symbolize leadership — a prestige earned through their pioneering work, the high quality of their product and the long and progressive service they have rendered to the professions and the trade.

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HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Look What You're Doing When You Paint That Wall

MAE STARK
Executive Housekeeper
Huntington Hospital
Huntington, N. Y.

IT IS only in recent years that hospitals have learned to use color scientifically for interior decorating. Good paint is expensive and the high cost of labor makes it necessary to be more than careful. Housekeepers cannot afford to make costly mistakes by doing a poor job of applying color. According to Ralph E. Sweet, well known color authority, the need for better use of color in all institutions is appalling. Speaking to a group of painting and decorating contractors in Massachusetts, he stated, "There is a crying need for color. Without it we would live in an anonymous world."

The right color or tint should be carefully selected, with the particular function of the sick room and its surrounding kept ever in mind. The deleterious effect of the wrong color on both patients and employes is now generally accepted. Much has been written, also, on the disadvantages of the wrong colors in operating rooms, delivery suites, x-ray departments and other treatment areas.

Colors Must Harmonize

If the corridor leading into the patient's room is not included in the redecorating program, the room color must be selected to harmonize with the existing color of the corridor. The adjacent territory must always be considered because if adjoining areas are not in harmony, the entire effect will be spoiled. The size of the room to be painted must also be kept in mind, as should the ceiling height, the number of windows and doors and the exposure. If there are too many windows and doors, for example, the undesirable effect can be minimized by painting the frames the same color as the walls.

When the decoration of a suite of rooms is being planned, it should be the duty of the housekeeper to check on the color to be sure that the correct hues are selected, bearing in mind the effect on patients and personnel. In the past the safe rule was to use buff—"it went with anything." Pea green is now being much overworked One finds corridors, offices, kitchens and many patients' rooms decorated in this yellow green, which is hard to take. Blue green is far better—if greens are used at all. Dead white has been in the discard for so long that it is no longer a problem. It does have its place, however, particularly on ceilings in rooms that need extra light.

Bright cheerful colors do better in north rooms where the sun seldom enters. Southern rooms require cooler colors. It is said that green and grays have a soothing effect, while yellow is likely to be stimulating.

The work areas in a hospital can be greatly benefited by some fresh thinking on decorating. What about the people who work in basements? For the most part these areas are below the street level and little, if any, sunshine enters. Usually they are lighted artificially and it is reasonable to expect that employes who must work in such locations would turn in a better performance if thought were given to color, if the bright yellow of the sun, the blue of the sky and the green of the trees could be used more extensively.

The reverse is true in the departments located at the top of the building. Here the light is strong, and soft colors—gray greens, rose, beige—are more suitable. The area devoted to pediatrics should be bright and cheerful with the clear blue of the sky and yellow of the sandy beaches.

The housekeeper needs to do some experimenting, mix colors for herself and be sure of what she wants before calling in the painters. Small cans of paint can be purchased inexpensively to do this job. A surface of not less than 2 feet square should be painted, left to dry for forty-eight hours and then viewed in the light of early morning, as well as when the sun is setting. Sometimes a room viewed in the cold, harsh light of morning looks quite different from the same room seen in the noonday sun. Again, in the evening, or under electric lights, a complete change in the effect will be noted. If and when the housekeeper decides that she has selected just the color she wants, she should firmly but kindly insist that the painters mix the colors to match her sample.

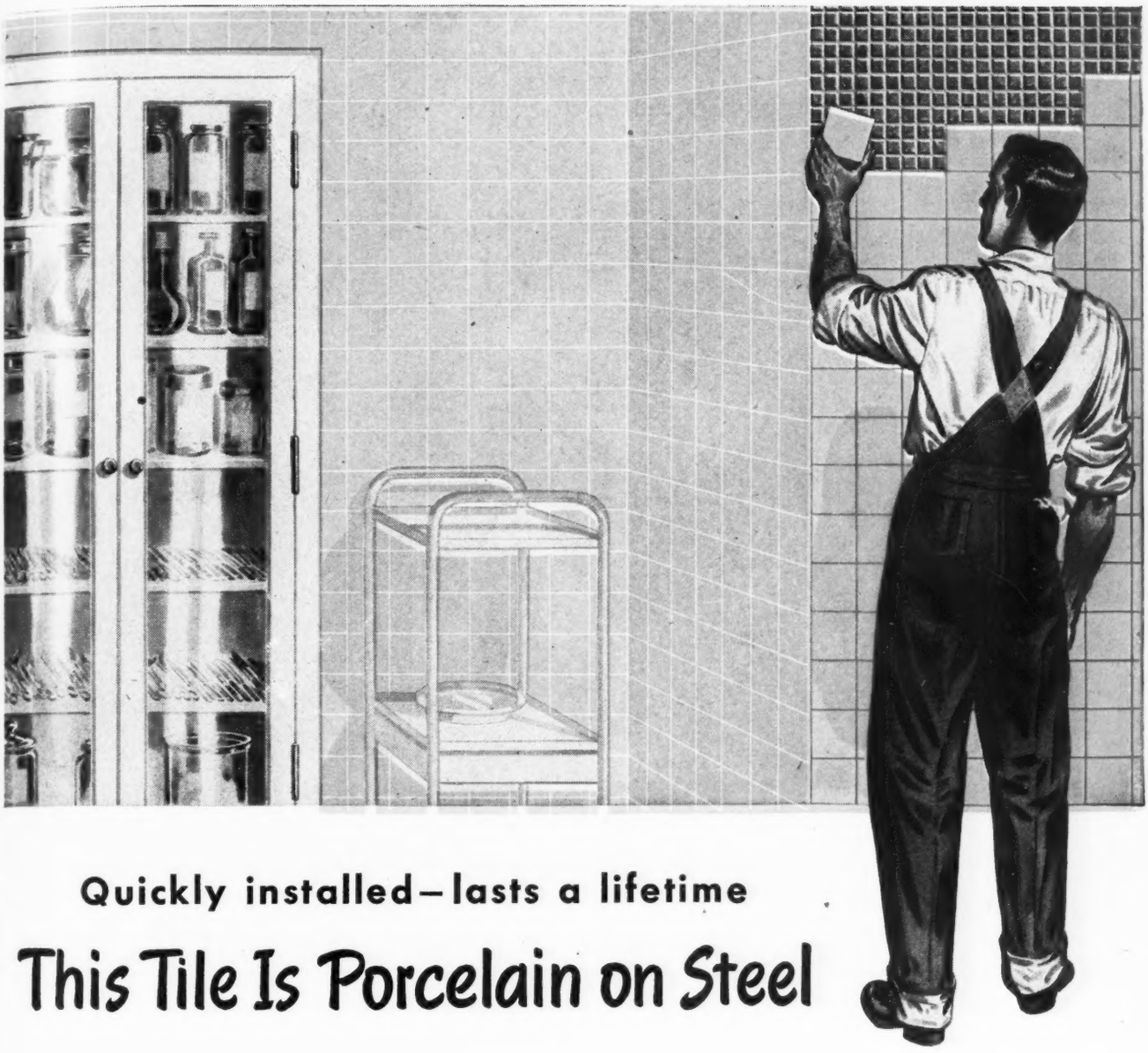
Every paint manufacturer in the country issues color charts without charge and many have books showing various color combinations that can be used in a room. One organization has issued a book particularly for hospitals; others will come in and make a survey at no cost to the hospital. What might be right for one institution might be all wrong for another. Each housekeeper must decide what is best for her hospital.

Know What the Name Means

When ready-mixed paints are purchased, the housekeeper must be sure that she knows what the name used to describe the color really means. All too often, a color like "apollo blue" is not nearly as soft as it sounds. It is necessary to know, for example, whether the finished effect wanted is a bluish or gray cast and, correspondingly, whether the paint purchased will have the desired effect. Slightly grayed colors are most successful in institutions.

Remember that painting is a costly job and if we are not careful it can cause some unhappy results. To say the least, our sins will stare us in the face each time we enter a room or go down a corridor.

Be sure you are right—then go ahead and paint.



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Porcelain on Steel

NEWS DIGEST

Finds Marriage, Not Other Jobs, Is Prime Cause of Nurse Shortage

WASHINGTON, D. C.—Marriage, not other jobs, appears to be the triple threat to the nursing profession, according to a preliminary report on the economic status of the nursing profession, released July 1 by the Bureau of Labor Statistics and made at the request of the National Nursing Council.

Most nurses who leave the profession do so primarily to get married rather than to seek more attractive work elsewhere. It is the potential nursing students who are lost to the profession by the hope of more economic security in other jobs.

The present nursing shortage is apparently due primarily to increased demands for nursing service at a time when many married nurses are leaving their profession and many potential nursing students find other fields of employment more attractive, Ewan Clague, commissioner of labor statistics, said in announcing the results of the study.

The study was based on mail questionnaires answered by some 22,000 nurses. Most of them, according to the answers, still derive satisfaction from the service rendered to the ill and the community. But some of the gripes regarding certain aspects of nursing were widespread enough to constitute a serious problem.

Leading sources of dissatisfaction concerned lack of provision for retirement and security against unemployment, rates of pay and opportunities for promotion and pay increases. Quantity and quality of nonprofessional help came in for a share of the complaints as did also hours of work, methods of settling grievances and opportunities for constructive criticism regarding procedures.

For those living outside the hospital, lack of adequate locker and restroom facilities was assailed. Timing and nature of nurses' duties were also targets for criticism.

Specifically, the survey revealed that: The average nurse worked 190 hours during October 1946 and earned from $170 to $175 if she provided her own living quarters, about $40 for a 44 hour week. About one out of four nurses who lived outside hospital walls received less than $145 in cash and a corresponding number received more than $195 a month. The average hospital nurse providing her own living quarters earned $172 a month plus about one meal a day. The one hospital nurse in five who lives in hospital quarters received an average of $160 in cash during October.

About one nurse in four was on duty at least 50 hours a week during October 1946. Overtime is not paid for in the majority of cases and about one hospital nurse in four is required to be on call beyond her hours on duty. A corresponding proportion work split shifts, divided by more than an hour off each day.

The average hospital nurse spent at least a fourth of her hours on duty in doing work that might be relegated to less trained personnel. Such duties included making beds, bathing and feeding patients, answering lights, taking meals to patients, taking patients to appointments and doing clerical work.

Nurses generally receive sick leave together with paid vacations of at least two weeks after a year's service. Most nurses, however, do not receive free hospitalization or medical care, nor are they covered by retirement pension plans.

Houses Disagree on Amending Science Bill

WASHINGTON, D. C.—The National Science Foundation Bill went July 17 to conferees of the two Houses in order that differences of opinion on amendments might be ironed out. The bill has been passed by both the Senate and the House, each branch of the law-making body adding amendments not agreeable to the other.

The bill, S. 526 in the Senate and H.R. 4102 in the House, is based on careful consideration during the 79th Congress and the current session of the 80th Congress of numerous bills proposing legislation on this subject. The bill would establish a national policy of fundamental research; initiate and support basic scientific research; grant scholarships and graduate fellowships in the sciences; foster the interchange of scientific information among scientists in the United States and foreign countries, and correlate its research programs with those undertaken by individuals and by public and private research groups.

Republican leaders in Congress considered this proposed legislation as among the "must" bills to be cleared.

President Signs Bill Providing $225,000,000 for Hospital Building

WASHINGTON, D. C.—With the signing of the appropriations act by the President July 8, construction of $225,000,000 worth of hospital and health facilities during the fiscal year of 1948 will be possible.

The act sets up a procedure patterned after the program of federal aid for highway construction, which obligates the federal government to pay up to $75,000,000 as its share of approved hospital construction. This sum represents one third of the cost. The combined total of federal, state and local funds brings the figure to a possible $225,000,000.

The states are assured under this arrangement that any hospital construction project approved by the Surgeon General creates a contractual obligation on the part of the federal government to meet its one third share of the cost. The $75,000,000 just appropriated for the fiscal year 1948 is the first money to be made available for construction. The sum of $225,000,000 was appropriated last year to assist the states in surveying exisitng hospital facilities.

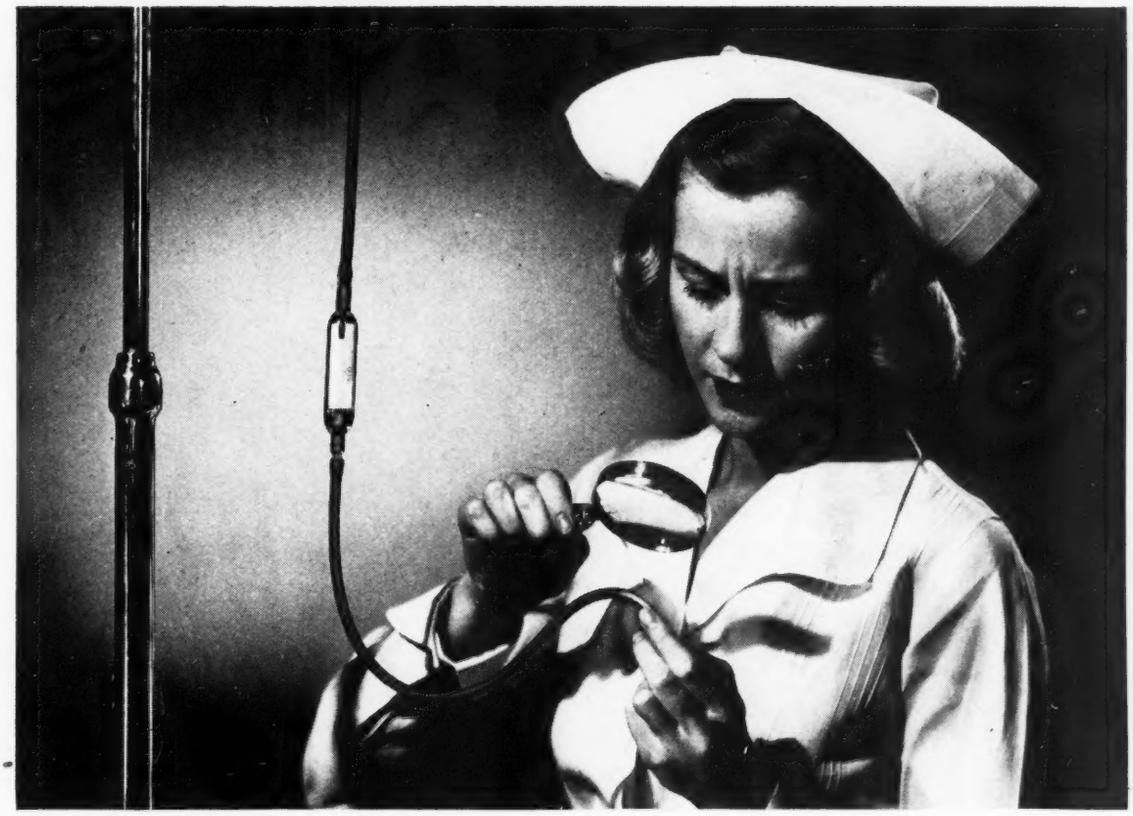
All states and territories, including the District of Columbia, are making surveys of their hospitals and health facilities. To date, three states have had their construction plans approved: Mississippi, Indiana and North Carolina.

Hearings on Pay Rise for Service Doctors

WASHINGTON, D. C.—The Senate committee on armed services held hearings July 8 on three bills to authorize $100 a month additional pay for doctors in the armed services. The most recent of these bills was introduced by Senator Pepper June 26, S. 1511, to provide additional inducements to physicians, surgeons and dentists to make a career of the U. S. military, naval and public health services.

The House armed services committee had previously reported favorably on H.R. 3851, a service doctors' pay bill, with amendments to include dentists.

Secretary Patterson predicted that the army will be short 3700 doctors by midyear of 1949 and short 4400 doctors by midyear of 1950, unless prompt measures are taken to induce more medical men to make military medicine their profession.



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Fighting Words Are Tossed at Hearings on Health Insurance

By EVA ADAMS CROSS

WASHINGTON, D. C.—We make too much of certain words which have become fighting words, like "compulsory" *versus* "voluntary," or "health insurance" *versus* "taxation," declared Dr. Thomas Parran under the insistent cross-questioning of Senator Donnell in the hearings July 9 before a Senate subcommitee concerning a national health program.

"Insurance, if it is compulsory, is a tax," continued Dr. Parran. "Every tax we pay is insurance." At least a start should be made in providing funds through taxation, insurance or both toward the goal of making available adequate medical care for all the people, he emphasized. S. 545 (Taft-Donnell) represents a modest approach toward this goal; S. 1320 (Wagner, Murray, Chavez), a comprehensive approach.

"The choice of approach should be a matter for Congress to determine, but I, for one, believe there should be no undue delay in the full attainment of this goal," reiterated the Surgeon General.

The essential health needs of the nation are of such scope and character that they can be met with reasonable adequacy only by the development of a comprehensive health program, said Federal Security Administrator Watson B. Miller. These needs cannot be met adequately through a program of the size contemplated by S. 545 or through any program that is operated on a means test basis.

James B. Carey, secretary-treasurer of the C.I.O., said at the outset that C.I.O. is urging endorsement of S. 1320. "Just another charity relief proposal," he characterized S. 545.

And so the fighting words went on: "Charity dole," "means test," "socialized medicine," "monopolistic practices." But the Surgean General of the U. S. Public Health Service said we had better quit dealing in semantics and get down to the job of providing an equal opportunity for health for all the people.

More than 1000 counties—one third of the counties of the nation—are without the benefits of full time public health services. In terms of life and death, Dr. Parran pointed out, this means that thousands of preventable deaths and thousands of disabilities occur.

D. C. Hospitals Charged With Discrimination Against Negroes

WASHINGTON, D. C.—District hospitals are charged with discrimination against Negro patients, doctors and medical students in a report by four local groups to the President's committee on civil rights.

Submitting the report were the local American Veterans' minorities affairs committee, the Southern Conference for Human Welfare's health committee, the District Medico-Chirurgical Society and the Physicians' Forum.

The report claims that Negro medical students at Howard University are barred from training opportunities at Gallinger Hospital where the majority of patients are Negroes; Negro doctors cannot enter Gallinger and St. Elizabeths except as visitors or patients; Negro patients seeking private rooms must go to northern hospitals to escape Washington's segregated wards.

Meantime, Dr. Louis T. Wright, board chairman of the National Association for Advancement of Colored People, accused the medical profession of a calloused attitude which ignores the problem of ill health among Negroes. Dr. Wright, a New York physician, was one of the principal speakers at the 38th annual conference here of N.A.A.C.P. Dr. Wright declared that the American Medical Association is chiefly responsible for this cruel and inhuman attitude on the part of the medical profession toward Negro health.

A survey made last year by the members of the racial relations committee revealed that all of the major hospitals in the District of Columbia, with the exception of Freedmen's, evidence some form of segregation or discrimination against Negro patients and none will admit a Negro doctor for practice. Only at Freedmen's and at two proprietary hospitals, representing 592 beds, can a Negro physician attend his patients, according to this survey.

Group Health Association last year voted its services available to Negro patients, whether employes of the federal or District governments or not. G. H. A. also decided in recent months to admit Negro physicians to the medical staff purely on a qualifications basis.

Pass Farm, Nursing Services Bill

WASHINGTON, D. C.—The President has signed S. 1072, a bill that would extend until July 1, 1949, the temporary legislation passed in 1943 to permit old people to enter the fields of nursing or agriculture without sacrificing their rights under old-age assistance.

The great floods have produced a shortage of nurses and agricultural labor in many parts of the country.

A.H.A. Convention in Four Sections Plus General Sessions

CHICAGO.—"Major Factors Affecting the Hospital Economy" will be the subject for the opening general session at the 49th annual convention of the American Hospital Association to be held in St. Louis, September 22 to 25. Speakers will include John H. Hayes of New York City, association president; R. O. D. Hopkins, New York, executive director of the United Hospital Fund, and Leon H. Keyserling, economic adviser to President Truman.

Other sessions of the convention will be broken into four sections on *professional practice, administrative practice, hospital planning* and *plant operation and special aspects of hospital administration*. The four sections will convene simultaneously and each session will be devoted to one broad aspect of the hospital's problems and new developments in the hospital field. Thursday afternoon's final general session will consist of a résumé of the discussions in all the special sessions.

General topics slated for special consideration at the various sessions include raising standards of medical practice, Blue Cross contract rates, the Hospital Survey and Construction Act, governmental hospitals, personnel management, care of the psychiatric patient, children's hospitals and pediatric units, nursing and nursing education, trustee-administrator relations, care of the tuberculous patient, purchasing, public relations, outpatient services and hospital costs.

Senate Appropriations on Hospital Projects

WASHINGTON, D. C.—The Senate appropriations committee on July 11 voted initial funds for construction of Washington's hospital center on the Naval Observatory grounds. The $1,700,000 appropriation is ear-marked for plans preliminary to actual construction. This sum has already been approved by the House.

For the National Institute of Mental Health at Bethesda, $850,000 was approved by the Senate committee. Of this amount, $450,000 will go for the purchase of a site and $400,000 for plans and other preliminary work. This appropriation also has House approval.

The Senate appropriations committee upped the House 1948 fiscal year appropriation for the Veterans Administration by $27,000,000. However, it voted down Senator Green's motion to increase the V.A. appropriation by $100,000,000 to carry out in full the medical program for the fiscal year of 1948. The Senator says he will carry the fight to the floor.

Pooling of Plasma in Blood Banks Condemned; Infections Can Result

CHICAGO.—The practice of pooling plasma for hospital blood banks was condemned as dangerous by Drs. Herbert Scheinberg, Thomas D. Kinney and Charles A. Janeway of Boston in an article appearing in the *Journal of the American Medical Association,* July 5. The authors, who are associated with Harvard Medical School and Peter Bent Brigham Hospital, reported 11 cases of serum jaundice or hepatitis transmitted by infected plasma. Four of the 11 patients died.

Carelessness in the selection of blood donors was emphasized by the Harvard physicians as an important contributing factor in the disease. It was pointed out that generally a history of donors is taken to exclude malaria, syphilis or existing acute illness. The doctors suggest that much more rigid requirements be used to detect possible sources of infection among donors.

In their opinion, blood should never be taken from a donor who has had jaundice or hepatitis or has had contact with a person suffering from jaundice, during a period of one year preceding the blood donation. They would also exclude donors who have received blood or blood derivatives or who have been patients in a hospital during the year preceding the donation of blood.

The physicians also suggest that whole blood or plasma fractionation products be used in preference to pooled plasma. "The basis for condemning the practice of pooling plasma," they concluded, "is the fact that the amount of infective serum necessary to produce the disease is incredibly small."

Hearings Held on Advance Planning for Public Works

WASHINGTON, D. C.—Hearings were held July 11 before the Senate committee on public works on S. 1423, the bill recently introduced to enable states and local governments to plan for the construction of public works. Such advance planning has been assisted for the last two years under the authority of Title V of the War Mobilization and Reconversion Act. The act expired June 30 by its own terms. Plans and specifications for many hospitals have been made through this program. S. 1423 would authorize $50,000,000 yearly for the advance planning program, all advances to be repayable to the federal government. Positive assurance would be required that local resources are sufficient to pay for the project and that construction will be started within four years.

Quinidine Control Is Assured Till Next March

WASHINGTON, D. C.—In clearing the extension of the Second War Powers Act for the President July 11, the Senate assured the extension of Title III of the act covering the control of cinchona bark, quinine and quinidine until Feb. 29, 1948.

Dr. Robert P. Fischelis, secretary of the American Pharmaceutical Association, has been urging Congress to keep quinidine under control for another year. The House-passed bill H.R. 3647 would have ended all effective control of the drug, he argued. The American Medical Association and the National Research Council also favored retention of allocation control of quinidine.

Under present controls, quinidine may be used only on a physician's prescription for prevention of irregular heartbeat in cardiac sufferers and for correction of such irregularities. There is now available about 136,000 ounces, an amount that represents approximately one third of the demand for the remainder of the year, according to Dr. Fischelis. He says that the present civil war in Java is one reason for fearing a continued shortage.

Consider Promotions, Pay of U.S.P.H.S. Officers

WASHINGTON, D. C.—The Senate bill regarding promotion of U. S. Public Health Service officers, including nurses, was reported favorably July 7. S. 1454 is matched by H.R. 3924 in the House and covers the same provisions. Hearings were held on the House bill July 3 with Dr. Thomas Parran and a number of other Public Health Service officials testifying in its favor.

The amendments proposed in the bill are necessary to keep the commissioned corps of the Public Health Service on a parity with the army as regards rates of pay and rates of promotion as proposed in the army promotion bill, H.R. 3830, already passed by the House.

Drs. Hawley and Wall Are Given Awards

WASHINGTON, D. C.—Dr. Paul R. Hawley, chief medical director of the Veterans Administration, has been given the Gorgas Award for 1947, V.A. announced July 7. The award is given annually by the executive council of the Association of Military Surgeons to some person who has made a notable contribution in the field of military medicine. It is sponsored by Wyeth, Incorporated.

Dr. Joseph S. Wall, Washington pediatrician, has been awarded the Carlos J. Finlay Medal for his services in advancing the cause of intercontinental pediatrics.

3 Major Hospitals Report NEW LOW in incidence of Impetigo!

Establishment of new methods of procedure—including introduction of the Mennen Antiseptic Baby Oil technique—was directly responsible for a drop in the incidence of impetigo cases among newborn babies in three major hospitals from 7.8% to 0.47%.

While impetigo cases *dropped* from 529 to 55 in these major hospitals, births *increased* from 6,752 to 11,707.

Extensive clinical studies prove that daily use of Mennen Antiseptic Baby Oil aids in providing a shield of antiseptic protection to infant skin. This antiseptic oil is an important factor in curbing impetigo, pustular rashes, miliaria, excoriated buttocks and diaper rash. Hospital staffs were also delighted with the discovery that Mennen Antiseptic Baby Oil WILL NOT STAIN HOSPITAL LINEN!

Results of clinical studies of Impetigo in 3 major hospitals

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11 months before Mennen Antiseptic Baby Oil	2193	125 CASES
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HOSPITAL "B"		
6 months before Mennen Antiseptic Baby Oil	272	54 CASES
16 months since Mennen Antiseptic Baby Oil	922	8 CASES
	BABIES	**IMPETIGO**
HOSPITAL "C"		
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29 months since Mennen Antiseptic Baby Oil	8722	43 CASES

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Proposed Legislation on Welfare and Health

WASHINGTON, D. C.—Senator Pepper has introduced a bill to provide every adult citizen with equal basic federal insurance, permitting retirement with benefits at 60. It also would cover total disability from any cause for certain citizens under 60. It would give protection to widows with children. It would provide an ever expanding market for goods and services through payment and distribution of such benefits in ratio to the nation's steadily increasing ability to produce.

Mr. Pepper also introduced a bill to provide additional inducements to physicians, surgeons and dentists to make a career of the U. S. military, naval and public health services. The House version of this proposal has already been reported with amendments.

Two bills introduced by Senator Gurney would, in S. 1523, authorize the creation of additional positions in the professional and scientific service in the War and Navy departments; S. 1528 authorizes the Secretary of War and the Secretary of the Navy to accept and use gifts, devises and bequests for schools, hospitals, libraries, museums, cemeteries and other institutions under the jurisdiction of the War or Navy departments.

The Senate committee on labor and public welfare approved July 1 in executive session the following two bills: S. 176 to aid in coordinating research relating to dental diseases and to establish a National Institute of Dental Research; and S. 1454 to amend the Public Health Service Act in regard to certain matters of personnel and administration.

S. 176 would establish a dental research institute in the U. S. Public Health Service; would provide grants of funds to nonprofit research institutes, universities and laboratories, and would set up research fellowships.

Identical bills were introduced in both Houses July 7 to equalize retirement benefits among members of the nurse corps of the army and navy. The bill seeks to give retirement benefits to army and navy nurses heretofore retired under the Act of May 13, 1926, which will be equal to such benefits as army and navy nurses now enjoy under a recently enacted bill.

Mr. Pepper introduced in the Senate a bill which would provide equal pay for equal work for women.

A Senate bill introduced July 2 proposes to facilitate the performance of research and development by and on behalf of the War and Navy departments. The Secretary of War and the Secretary of the Navy would each be authorized to set up a research advisory committee.

A bill introduced July 9 in the House would promote fundamental research in the sciences by allowing for income tax purposes an additional deduction to individuals and corporations.

H. R. 3125 was reported favorably July 9 by a House committee and the bill was placed on the Senate calendar. It proposes to establish in the medical departments of the regular army and navy a medical service corps with a reserve component which will be composed of pharmacists, sanitary engineers, optometrists, psychologists, bacteriologists and business administrators.

Columbia Aids Crippled

NEW YORK.—Under the "operating affiliation" of Columbia University and the Institute for Crippled and Disabled, New York City, a program of rehabilitation and reeducation for the disabled has been started. Under terms of the affiliation, Columbia University will nominate the medical staff of the institute, formulate its medical policy and direct its medical program. The institute's rehabilitation facilities will permit the training of physicians, nurses and social workers in physical therapy and related professions.

Children's Carnival Is Sponsored by Philadelphia Blue Cross

PHILADELPHIA. — Associated Hospital Service, the Philadelphia Blue Cross, sponsored a children's carnival in Fairmount Park here on July 4, emphasizing the theme "good health begins at home." More than 20,000 persons, half of whom were children, attended the carnival which was sponsored jointly by Blue Cross, the Council of Social Agencies, Heart Association, Society for Crippled Children, Community Chest and a number of individual hospitals and other agencies in the health field.

Believed to be something new in the endeavor of Blue Cross to play a complete rôle in community life, the carnival was planned, according to E. A. van Steenwyk, Blue Cross director, to "show the community of which we are a part how ready we are to serve it and how able we are to build a healthier body of citizens."

Features of the carnival included contests to select the fattest and tallest children, marionette shows, a freckle counting machine, a crawling race for babies and a diaper changing contest for fathers. Exhibitors in the health fields had educational displays and distributed informatve health literature. The Philadelphia Mouth Hygiene Association, it was reported, gave away 15,000 toothbrushes at the carnival.

Philadelphia Blue Cross Carnival.

"While it was a day of fun," Mr. van Steenwyk said, "it was also a day on which the public mind was impressed with the fact that Blue Cross and the other agencies and hospitals were sitting down with their guests to enjoy a holiday to entertain and yet to deliver a few wholesome admonitions."

Surplus Property Disposal Again Under Fire

WASHINGTON, D. C.—Billions in war surpluses will be sent to the political junk yard if Congress insists that present priorities be retained, Robert M. Littlejohn, War Assets Administrator, warned July 2. Littlejohn was answering criticism leveled at W.A.A. by the surplus property subcommittee of the House committee on expenditures in executive departments.

The subcommittee recommended that existing priority provisions of the Surplus Property Act be retained except as to real estate. The Slaughter committee, predecessor to the present one headed by Congressman Rizley, had recommended that the Surplus Property Act be amended to eliminate all existing priority categories, with the exception of federal governmental agencies, and that all surplus sales be put on a first-come, first-served basis.

Among other charges brought by the subcommittee against W.A.A. was that there had been too much red tape in the administration of priorities.

Two Errors Corrected

In the article by Dr. Basil C. MacLean on page 55 of The MODERN HOSPITAL for May 1947, it is stated that the cost of building a veterans' hospital is "around $25,000 a bed." This figure should have been $20,000. In the same article the Strang Clinic of Memorial Hospital, New York, was incorrectly named as the Strong Clinic.

Pennsylvania Nurses Set Up Minimum Wage, Hour Demands

HARRISBURG, PA.—Establishment of statewide minimum working standards for institutional staff nurses was announced by the Pennsylvania State Nurses' Association last month in letters directed to hospital superintendents, nursing directors, medical society officers and editors throughout the state.

The minimum salary named by the association was $180 for general duty, $205 for head nurses and $230 for supervisors. A 44 hour week was named as the standard with the recommendation that this be reduced to 40 hours in 1948. The schedule of rates and hours was based on extensive studies of local, state and national conditions, an association announcement said.

"These standards still do not equal those already in effect in New York, or even in Veterans Administration hospitals in our own state," Letitia Wilson, association president, declared.

"A beginning salary of $200 per month is a desirable goal, but nurses recognize the fact that hospitals here in Pennsylvania may not be able to make so great a change immediately. Even the present standard of $180 will not be effective until October 1, so as to allow hospitals time to adjust their budgets. In certain areas salaries higher than the minimum will be necessary to hold the nurses in their jobs and to attract recruits, but we are confident that hospital authorities will work cooperatively with us in trying to give the citizens of Pennsylvania the nursing service they need and should have."

Discharge Is Liberalized for Army Doctors, Nurses

WASHINGTON, D. C.—Liberalized discharge criteria for Army doctors and nurses became effective July 1. All nonvolunteer doctors, dentists, dietitians and other medical department officers are now eligible for separation upon completion of two years' service. Nurses, physical therapists and officers of the medical administrative corps, except those who have volunteered for extended service, are eligible for immediate separation.

Critically needed medical officers can still be individually retained when it is essential for the proper care of patients. At present, there are 36 specialists being retained as essential in army hospitals.

Summer Institutes Fail to Draw; Postponed

CHICAGO.—Because vacations and other summer activities interfered with registrations, the American Hospital Association has canceled or postponed several of the institutes on various phases of hospital operation which were scheduled for the summer months, it was announced at association headquarters last month.

The institute on nursing scheduled for August 25 to 29 in Chicago has been postponed and is now tentatively scheduled for the coming winter. An institute on hospital planning, originally scheduled for August 18 to 22, will be held instead in Chicago December 1 to 5.

The institute on advanced accounting scheduled for August 25 to 29 at New Orleans has been canceled.

Senate Passes World Health Bill

WASHINGTON, D. C.—The Senate passed on July 7 the Senate joint resolution providing for membership and participation by the United States in the World Health Organization. An amendment was made to the resolution reserving the right to the United States to withdraw from the organization on a ninety day notice. The measure now goes to the House.

A.C.S. to Hold Hospital Conference Sept. 8 to 11

CHICAGO.—As a part of its annual clinical congress, the American College of Surgeons will hold a four day hospital standardization conference from September 8 to 11 at the Waldorf-Astoria, New York City. This will be the twenty-sixth annual conference. The main speakers at the opening general assembly will be Dr. Harold L. Foss of Danville, Pa., on "Need for Efficient Medical Staff Organization and Control of the Professional Work of the Hospital"; Graham L. Davis of Battle Creek, Mich., on "Better Hospital Facilities for Rural Patients"; Dr. H. Prather Saunders of Chicago on "Planning for a Career in Surgery"; Brig. Gen. Robert W. Johnson on "The New Era in Personnel Relations and Its Meaning for Hospitals," and Dr. Warren H. Cole and Thomas Jones of Chicago on "The Potentialities of the Medical Motion Picture for Teaching Purposes."

The session will close with a showing of the new film produced by the college, "Anomalies of the Bile Duct and Blood Vessels; Strictures of Common Duct."

Succeeding hospital conferences will be on the following topics:

Monday Afternoon: Current Problems in Medical Service in Hospitals. Conducted by Dr. Joseph Turner, New York City.

Monday Evening: Presidential meeting.

Tuesday Morning: Improving Food Service in Hospitals. Conducted by Margaret Gillam, dietary consultant, American Hospital Association.

Tuesday Afternoon: Improving Nursing Service in Hospitals. Conducted by Dr. Claude W. Munger, St. Luke's Hospital, New York City.

Tuesday Evening: Joint session for hospital trustees, medical staff officers, and administrators. Conducted by Raymond P. Sloan, editor, The MODERN HOSPITAL.

Wednesday Morning: Personnel and Public Relations. Conducted by Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis.

Wednesday Afternoon: Improving Medical Records in Hospitals, joint session with the American Association of Medical Record Librarians. Conducted by Dr. Robin C. Buerki, director of hospitals, University of Pennsylvania.

Wednesday Evening: Forum on Trends in Hospital Administration, New Ideas and Procedures and Special Hospital Problems. Conducted by Leo M. Lyons, director, St. Luke's Hospital, Chicago.

Thursday Morning: Forum on Special Problems. Coordinators: Dr. Buerki and Everett W. Jones, vice president, The Modern Hospital Publishing Company.

Thursday Afternoon: Special Problems of the Small Hospital in Meeting the Standards of the American College of Surgeons. Conducted by Dr. Harvey Agnew, secretary, Canadian Hospital Council.

Thursday Afternoon: Symposium on Graduate Training in Surgery and the Surgical Specialties. Moderator: Dr. Dallas B. Phemister, University of Chicago.

Thursday Evening: Special Conference on the Point Rating System. Conducted by Dr. Agnew and Dr. Henry G. Farish, American College of Surgeons.

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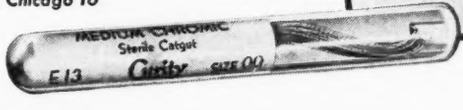

Blue Cross Now Has 28,000,000 Enrollees, Publicity Men Told

CHICAGO.—Present Blue Cross enrollment totals 28,000,000 members, Richard M. Jones, Blue Cross Commissioner, told a public relations conference for executives in Chicago, July 18. Tracing the growth of Blue Cross enrollment in recent years, Mr. Jones said that there is a noticeable trend for the payment of Blue Cross membership fees by employers. Approximately 8 per cent of present membership fees are now paid by employers, Mr. Jones said.

Pointing out that the studies made by the Committee on the Cost of Medical Care are now nearly 15 years old but remain the only definitive source of information on family health costs, Mr. Jones suggested that negotiations between hospitals and Blue Cross plans might be aided substantially by a new study aimed at determining how much the public can pay or will pay for hospital and medical services.

In a paper on hospital-Blue Cross relations, Irene McCabe, public relations director of Blue Cross in Missouri, said that all differences between hospitals and plans boil down quickly to a matter of money. Nevertheless, she said, the relationship is harmed by mutual distrust and lack of confidence. She recommended the frank interchange of operating information as a basis for better hospital-Blue Cross relations.

Others who addressed the conference, which was attended by 50 directors and public relations officers, included C. R. Gruver, public relations director of Philadelphia Blue Cross; Marvin E. Walker, Cincinnati; Antone G. Singsen and Lawrence C. Wells of the Blue Cross Commission office; Sue Jenkins, Kansas City, and Edson P. Lichty of Chicago.

VHP-1 to 5 Are Revoked

WASHINGTON, D. C.—With the revocation June 30 of VHP-1 along with its supplements and directions, hospitals and other nonhousing construction projects are free to proceed without further authorization. The one exception comes under Construction Limitation Regulation (issued under the Housing and Rent Act of 1947) which covers construction work on structures to be used for recreational or amusement purposes.

VHP-3, 4 and 5 are also revoked. VHP-3 covered restrictions on the use of cast-iron soil pipe; VHP-4 covered production restrictions on cast-iron soil pipe and fittings, while VHP-5 concerned delivery restriction on Douglas fir and Western pine shop lumber.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Edmonton, Alta, Oct. 20-26.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Hotel Commodore, New York City, Sept. 8-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 22-25.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Jefferson, St. Louis, Sept. 20-22.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Waldorf-Astoria Hotel, New York City, Sept. 8-12.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Radisson, Minneapolis, Sept. 2-6.

AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-17.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 22-25.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Del Coronado, San Diego, Calif., Oct. 3-Nov. 7.

AMERICAN PHARMACEUTICAL ASSOCIATION, Milwaukee, Aug. 24-30.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 19-21.

AMERICAN PUBLIC HEALTH ASSOCIATION, Atlantic City, N. J., Oct. 6-10.

CANADIAN HOSPITAL COUNCIL, Winnipeg, Man., Oct. 16-18.

NATIONAL LEAGUE OF NURSING EDUCATION, Seattle, Sept. 8-11.

NEBRASKA HOSPITAL ASSEMBLY, Fontenelle Hotel, Omaha, Nov. 13-14.

1948

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.

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Recommends General Hospital Treatment for Communicable Diseases

NEW YORK.—Emphasizing significant advances in the control of acute communicable diseases and the decrease in use of special hospitals for the treatment of patients with these diseases, the Hospital Council of Greater New York last month presented details of its master plan recommendation that beds for acute communicable diseases be placed in general hospitals.

Authorities in the field of communicable diseases, the council said, "have pointed out that under the special safeguards of proper construction, adequate sterilization equipment and a sufficient staff of trained personnel, patients with these diseases can be cared for in general hospitals without danger either to the personnel or to the patients in the noncommunicable units of the hospital."

The seasonal nature of acute communicable diseases causes these special hospitals to stand empty most of the year, thereby wasting the skill of the staffs required to maintain them and making them unduly costly to operate, the council explained. "Provision should, therefore, be made to furnish the necessary facilities during the months when hospitalization for acute communicable diseases is high, as well as to eliminate the burden of maintaining the costly isolation hospitals.

"It is not feasible to close a hospital and disband the staff during the slack periods," the report continued, "but a unit or ward in a general hospital might easily be closed or converted to other uses during periods of low demand."

On the basis of this plan, the council recommended that 0.1 bed per thousand population be provided in general hospitals for the care of patients with acute communicable diseases, or 800 beds for the expected population of 8,000,000 in New York City in 1950.

The hospital council also presented a discussion of the community needs for adequate facilities to care for patients with mental diseases, stating that nearly half the beds of all classifications called for in its master plan are needed for the care of patients with mental diseases. Recommendations in the council's master plan call for eight beds per thousand population, or 64,000 beds for the care of mental diseases among the residents of New York City in 1950.

"Progress in the treatment of mental diseases has indicated the need for the integration of some of the facilities for psychiatric patients into the field of general care," the council reports. "It is felt by many that the general hospital is not offering complete service to its patients when it fails to provide facilities for psychotherapy."

Funds Approved for TB Survey, Other D. C. Needs

WASHINGTON, D. C.—A sum of $66,000 for a mass tuberculosis case finding survey of Washington was approved by the House appropriations committee July 8. The U. S. Public Health Service will contribute close to $100,000 for the survey and the District Tuberculosis Association will add an approximate $33,000.

Gallinger Hospital's estimate was reduced by $333,000, but the appropriation of $3,450,000 was an increase of $333,000 over last year's appropriation.

The committee cut $229,000 off the estimates of money needed for St. Elizabeths Hospital.

Women Officers in Regular Army

WASHINGTON, D. C.—Col. Florence Blanchfield, superintendent of the army nurse corps, in a ceremony on July 18 in Chief of Staff Eisenhower's office, received a regular army commission, the first woman ever so commissioned. This is the result of the recently enacted law establishing the army nurse corps as a commissioned corps in the regular army. Col. Blanchfield will retire August 31.

Medical Board Reports to Atom Energy Body

WASHINGTON, D. C.—The U. S. Atomic Energy Commission released July 5 the report of its medical board of review. The board chairman, Dr. Robert F. Loeb of Columbia University, stressed the need for research and training in all aspects of the application of atomic energy to medical and biological problems.

Among other recommendations, the board of review advised that the commission: continue to provide isotopes (for tracer research) for the study of fundamental medical and biological problems; encourage, consistent with the demands of national security, the publication of scientific papers dealing with medical and biological research and development; explore and consolidate relationships with other governmental agencies, particularly the Public Health Service and the armed forces, in fundamental biological and medical research and in training personnel in these fields.

The commission was advised to set up fellowships in the field of radiation effects. A large number of young, available and active scientists with continuing experience in atomic fission, its dangers and its potentialities would assure the safety of our country more certainly than the memory of priceless but static knowledge in a declining team of former collaborators.

Finally, the medical board recommended that the commission establish an advisory committee for biology and medicine with a medical director to assume general responsibility for the research and training problems.

Wisconsin Blue Cross Moves to New Quarters

MILWAUKEE.—The Wisconsin Blue Cross plan for hospital care, which has been located in the Loyalty block, opened new headquarters last month in a building at 826 North Plankington Avenue, Milwaukee, L. R. Wheeler, executive secretary, announced.

The move to larger quarters was necessary in order to carry on expanding activities, Mr. Wheeler explained. The plan has been so cramped for space in its present location that it has been difficult to give adequate service to its members and hospitals, it was explained. It is expected that the present move will enable the plan to carry on its business more efficiently and will effect a substantial saving to the subscribers.

Chicago's 1947 Class Gets Jobs

CHICAGO.—Graduates of the University of Chicago course in hospital administration in the class of 1947 have accepted hospital appointments as follows, it has been announced: J. E. Barnes, Genesee Hospital, Rochester, N. Y.; G. J. Bartel, St. Barnabas Hospital, Minneapolis; L. O. Bradley, hospital administration course, University of Montreal; D. C. Carner, Northwestern Hospital, Minneapolis; C. G. Frantz, Milwaukee General, Milwaukee; H. Gibson, Highland-Alameda County Hospital, Oakland, Calif.; M. C. Jones, Orange Memorial Hospital, Orange, N. J.; H. M. Krauss, Coldwater Community Hospital, Coldwater, Mich.; C. R. Mallory, U. S. Marine Hospital, San Francisco; D. W. Patrick, U. S. Marine Hospital, Detroit; D. L. Price, Methodist Hospital, Indianapolis; G. K. Thompson, Graceland College, Lamoni, Iowa.

Hopkins Gets Research Grant

BALTIMORE.—Dr. Isaiah Bowman, president of Johns Hopkins University, announced July 11 that a $1,000,000 research grant had been received by Johns Hopkins School of Medicine from Undersecretary of State and Mrs. Clayton. The gift was made as a permanent endorsement and is contained in 20,000 shares of common stock in Anderson, Clayton and Company.

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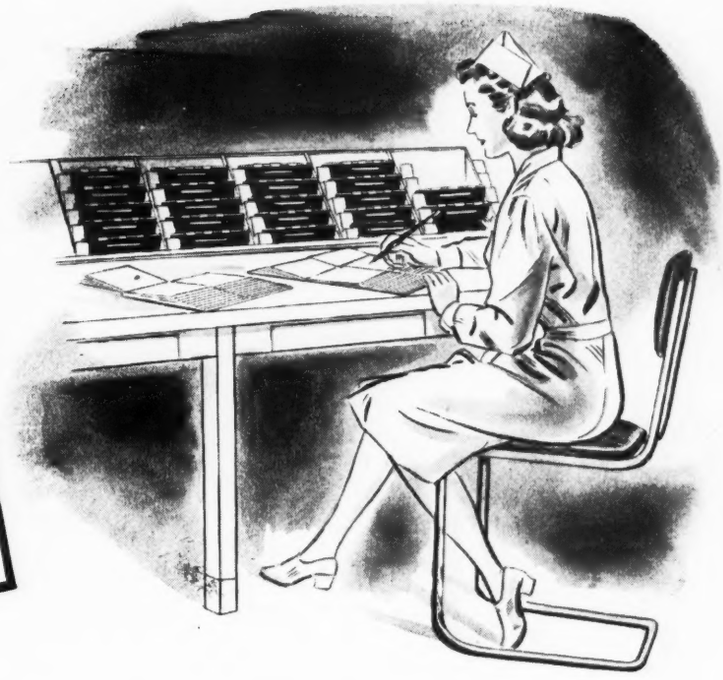

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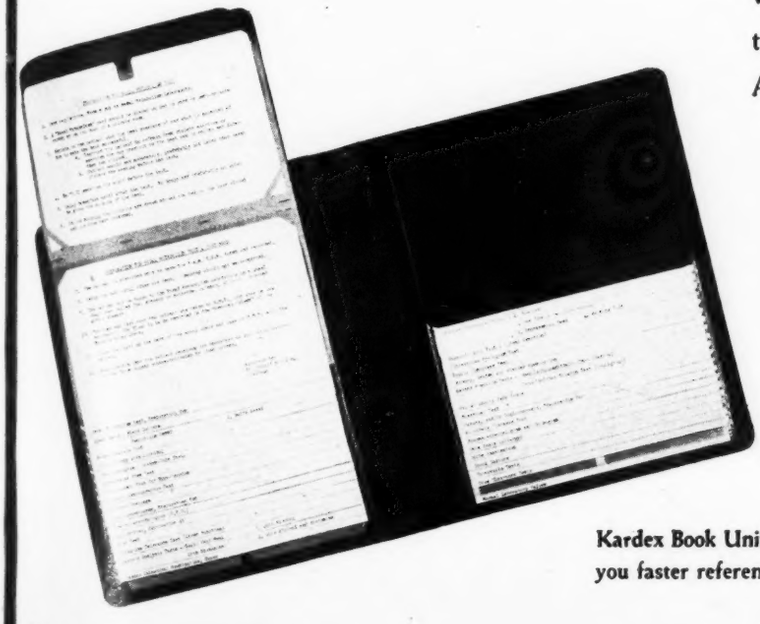

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Hospital Construction Projects Authorized

WASHINGTON, D. C.—On the list of nonhousing construction authorizations by the Office of the Housing Expediter is that of a general hospital at Hazelton, Pa., to be known as St. Joseph's Hospital. The structure will have five stories and a basement and is estimated to cost $1,113,600.

Our Lady of Lourdes Hospital, Camden, N. J., has received authorization to construct an eight story general hospital at an estimated cost of $2,500,000. Acquisition of a 9 acre site for a Veterans Administration hospital in Boston has been announced. A 1000 bed general medical and surgical hospital will be located 3 miles from Boston's business district.

Two minor changes in V.A.'s hospital program are:

1. Substitution of a 100 bed general medical and surgical hospital to the existing V.A. hospital at Tuskegee, Ala., in place of a proposed 164 bed neuropsychiatric addition. The present hospital at Tuskegee has a standard capacity of 2052 NP beds.

2. Conversion of the existing 317 bed V.A. chronic hospital in Atlanta, Ga., to a 225 bed tuberculosis hospital, pending completion of a proposed 250 bed TB hospital at Americus, Ga.

Phenix City Hospital Will Open September 1

PHENIX CITY, ALA.—The new Phenix City Memorial Hospital, built to honor veterans of all wars, will be open for patients not later than September 1, Arthur L. Bailey, administrator, announced last month. Personnel is now being selected and equipment is being installed in the 73 bed structure, Mr. Bailey said. The hospital was financed partly by city taxes and in part by voluntary contributions, he reported.

Phenix City Memorial Hospital.

"This community felt that in building the hospital it not only would set up a memorial to those who had fought so valiantly for our freedom," Mr. Bailey declared, "but at the same time would alleviate the suffering and improve the health of the citizens of this section."

Mr. Bailey came to Phenix City last April to supervise the new project. He was formerly administrator of the Keys-Houston Clinic Hospital at Murray, Ky., the Union County Hospital, Morgansfield, Ky., and the Herbert Thomas Memorial Hospital, South Charleston, W. Va.

Hold Joint Conference on Education in Chicago

CHICAGO.—A conference on education in hospital administration under the joint sponsorship of the American Hospital Association and the American College of Hospital Administrators was held in Chicago June 26 to 30. Representatives of the hospital administration programs at Chicago, Northwestern, Columbia, Washington and Yale universities attended the conference which was devoted largely to curriculum planning.

In addition to discussion of various phases of the educational program for hospital administrators, faculty training and control, seminar planning, individual assignment and other subjects, the conference included a demonstration hospital field trip conducted for the purpose of studying a single hospital department.

G.H.I. Offers Surgical, Obstetrical Services

WASHINGTON, D. C.—Group Hospitalization, Incorporated, contracted June 24 with the District Medical Society to provide prepaid surgical and obstetrical care for its subscribers. Participation will be limited at first to the 310,000 persons in the metropolitan area who belong already to the existing G.H.I. service which covers hospital fees only. The new plan will be known as the Medical Service Plan of the District of Columbia.

The District Medical Society will enroll the doctors while G.H.I. will sign up the patients and attend to the administrative work. Subscribers will have their choice of any doctors participating in the plan. Some 600 physicians have already signified their intention of taking part.

The medical service plan is only in its initial stages. At first, it will take care of a patient's bill for surgery and obstetrics and for x-ray, anesthesia and laboratory services needed in the operation. It does not apply yet to doctors' fees for purely medical service during hospitalization. The ultimate objective is to include such fees.

Permanent Commissions Offered to Women

WASHINGTON, D. C.—Unmarried nurses, dietitians, physical therapists and occupational therapists who desire appointment in the army nurse corps or women's medical specialists corps of the regular army may now apply, according to the Office of the Surgeon General. Recent legislation authorizes permanent commissions to these groups.

Those who served honorably during World War II will be given preference. Applications from nurses up to 35 years old are acceptable at this time; from dietitians, physical therapists and occupational therapists, up to 45.

Nurses, physical therapists and dietitians are also able under the new law to apply for commissions in the officers reserve corps.

Eligible for G.I. Benefits

WASHINGTON, D. C.—Commissioned officers of the U. S. Public Health Service who were assigned to and served with the armed forces during World War II and are now back on duty with the Public Health Service are eligible for G.I. benefits, according to an announcement of the Veterans Administration. These benefits include education or training; subsistence allowances for those in education or training, and loan guarantees for homes, farm or business purposes.

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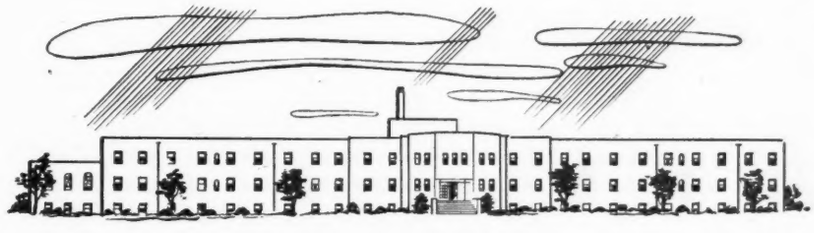

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Physicians Report Difficulty in Getting Hospital Appointments

CHICAGO. — Well trained, competent physicians who have located in new communities following their return from service with the armed forces should be given opportunities, and particularly hospital privileges, similar to those offered other practitioners in the community, the board of regents of the American College of Surgeons declared at a meeting last month.

Complaints have come from several sources of difficulties that are placed in the way of physicians seeking hospital privileges, a report from the college stated. Several specific cases of seemingly unjustifiable delay in making hospital appointments were studied by the board of regents which also considered such contributing factors as the shortage of hospital beds and the resulting long waiting list of patients.

Following the study, the board of regents adopted the following resolution:

"WHEREAS it has come to the attention of the American College of Surgeons that many well trained surgeons, especially returned veterans, who have located or have signified their intention of locating in communities where there are hospital facilities, have been denied hospital privileges until they had been in residence in that locality for six months to a year.

"BE IT RESOLVED that the board of regents of the American College of Surgeons disapproves of the practice, and although fully cognizant of the shortage of hospital beds, the board believes that such well trained, competent and ethical individuals should be given opportunities similar to those offered to establish medical practitioners of the community."

Urges More Facilities for Chronically Ill

CHICAGO.—The need for additional hospital facilities for convalescent and chronically ill patients was emphasized by Dr. Theodore R. Van Dellen in a recent "How to Keep Well" column appearing in the *Chicago Tribune-New York News* syndicate newspapers.

"A general hospital should not be filled with chronic patients," Dr. Van Dellen asserted, "as ordinary illnesses and emergencies would have to be neglected. Chronic patients should be in a nursing home or place that can handle the infirm," he continued. "Unfortunately, there are too few accommodations of this type. Furthermore, many of the institutions that exist today must be made more attractive if they are to lose the stigma now attached to them. Something must be done as the problem is becoming more acute each year. People are living longer and are developing maladies which are partially incapacitating and demand a long convalescence."

Dr. Van Dellen described a survey made in a Chicago hospital recently which revealed that more than 20 per cent of the patients had been hospitalized for eight weeks or more. By urging that as many as possible of these patients be discharged to provide space for the acutely ill, he reported, the staff was able to remove approximately three quarters of these long term patients from the hospital within a few days.

Dr. Van Dellen's column appears in a number of newspapers throughout the country with an estimated 7,000,000 readers.

Light on V.A. Outpatient Clinics

WASHINGTON, D. C.—The Veterans Administration July 11 answered questions most frequently asked by veterans concerning outpatient treatment in a V.A. hospital clinic or at the office of their own physician at government expense. This is another of a question-answer series, an earlier one being hospitalization for veterans at government expense.

V.A. Medical and Hospital Programs Escape Economy Ax

WASHINGTON, D. C.—The independent offices appropriation bill passed by the House June 19 handled with care the medical and hospital programs of the Veterans Administration. The House committee on appropriations reported that no recommendation suggested the reduction of even one penny in medical care to those eligible.

Recommended for administration, medical, hospital and domiciliary services was the sum of $878,040,780. The reduction of close to $39,000,000 reflected in this amount concerned administrative expenses.

Before passing the bill, however, the House voted down a move to add $100,000,000 to the V.A. medical care program. Maj. Gen. Paul R. Hawley, chief medical director, had told the House committee on veterans' affairs that the Veterans Administration was short 28,000 personnel and $100,000,000 for carrying out a complete medical program in 1948. Both Republican and Democratic leaders of the House appropriations committee have declared that additional money would be forthcoming once the need is justified.

The House also halted construction of the new $15,000,000 veterans' hospital on the Nevius tract pending further investigation by the House appropriations committee. An economy-minded representative claimed that other sites are available near by which cost less than the Nevius tract. V.A. has already spent in the neighborhood of $100,000 on architectural and engineering plans for this site in Arlington.

The House likewise suspended construction plans for a new V.A. hospital at Tallahassee, Fla.

Maryland Blue Cross Enrolls Its 500,000th

BALTIMORE.—The 500,000th subscriber to Maryland Hospital Service was enrolled last month, J. Douglas Colman, Blue Cross director, announced. Maryland Hospital Service has now enrolled 25 per cent of the state's entire population, Mr. Colman said.

The 500,000th subscriber, Edward J. Davis, is an employe of the Koppers Company. Speaking for the company on the occasion of Mr. Davis' enrollment, Walter F. Perkins, vice president, said: "We are proud to be one of the earlier employers in Maryland to cooperate with Blue Cross. For our employes Blue Cross has meant the assurance of hospital care when needed. Their effectiveness as producing members of society is enhanced when their families are thus covered. In combining the typically American traits of personal independence and community responsibility, Blue Cross has performed a useful function for our employes and for society."

Chicago Must Solve Hospital Bed Shortage

CHICAGO.—Solution of the hospital bed shortage was named as a major health aim for the Chicago area by Surgeon General Parran of the U. S. Public Health Service at a meeting of the Chicago Council of Social Agencies last month. Dr. Parran met with several hundred health, welfare and civic leaders to present final recommendations following the extensive survey of health and hospital facilities in the Cook County area which has been conducted with the aid of the U. S. Public Health Service during the past several months.

Coordination of health activities under a fully staffed and adequately equipped health department and improvement of water purification and sewage disposal were named among the other important recommendations.

The shortage of hospital beds in the Chicago area was estimated in the survey to be about 16,000.

"Physiatrists" Now Have Specialty Board

NEW YORK.—The Advisory Board of Medical Specialties has approved the establishment of an American Board of Physical Medicine which will qualify physicians as specialists in this field of medical practice, it was announced in the annual report of the Baruch committee on physical medicine, published recently.

Specialists in physical medicine will be known as "physiatrists"; the term, recommended by the committee, has been adopted by the Council on Physical Medicine of the American Medical Association, the American Congress of Physical Medicine and the Society of Physical Medicine.

Among the projects sponsored by the committee from which the physically disabled are receiving immediate benefits are three centers for physical medicine and rehabilitation at Columbia University, New York University and the Medical College of Virginia, recipients of grants totaling $900,000. The three centers, which are being developed over a ten year period, are designed to serve as models for medical schools and hospitals both in this country and abroad.

Benefits to the disabled will also come from the training of physicians and other personnel in physical medicine and rehabilitation and from research now being conducted under grants from the committee in nine other leading universities. These schools are Massachusetts Institute of Technology, Harvard University, University of Minnesota, University of Southern California, University of Iowa, Marquette University, Washington University and the University of Illinois. A similar program is to be started soon at George Washington University School of Medicine.

In addition to financial support for research and training, the Baruch committee furnishes professional consultation and advice to the universities participating in its program through its scientific advisory committee.

Practical Nurses Open Registry in Washington

WASHINGTON, D. C.—The Undergraduate and Practical Nurses Association has opened its own nonprofit nursing registry. Fees will be limited to $7 for an eight hour day and $10 for a twelve hour day. The new nursing service has been established to protect the public from persons representing themselves as trained nurses but who lack sufficient experience to care for the sick, and to safeguard the nurses themselves from exploitation by many existing registries operated for profit.

The nurses' registry requires members to furnish proof of three years' practical experience, including a year in the District and testimonials of efficiency from two doctors and two former patients. Patients are charged the same fees as those now established for practical nurses who are affiliated with the registry maintained by the Graduate Nurses Association.

A bill to require practical nurses to be examined for their medical experience and licensed to practice in the District of Columbia has been tabled by the commissioner who opposes granting licensing power to the existing nurses' examining board.

School Celebrates 70th Year

NEW YORK.—The Cornell University-New York Hospital School of Nursing which this year observed its 70th anniversary has been accepted for active membership in the Association of Collegiate Schools of Nursing, it was announced recently. Of the more than 1200 nursing schools in the country, only 29 are members of this association and of these only 16 offer the basic preparation in nursing. The additional number offers only university programs for graduate nurses.

Announce Date of Chicago Institute for Hospital Administrators

The fifteenth Chicago institute for hospital administrators will be conducted by the American College of Hospital Administrators in Chicago September 2 to 12, the college announced last month. Sponsoring organizations include the University of Chicago, American Hospital Association, American Medical Association, American College of Surgeons, Chicago Hospital Council. This year's institute is planned to meet the needs of administrators and assistants seeking an overall view of hospital administration, a college announcement stated.

All sessions of the institute, except field trips to various hospitals in the area, will be held at the International House on the University of Chicago campus.

Administrators and assistant administrators of recognized hospitals will be eligible for enrollment, which is limited to 100 registrants. The institute will be under the general direction of Dr. Malcolm T. MacEachern.

Gets $225,000 Annex

GETTYSBURG, PA.—A new building known as the Christian H. Musselman annex has been opened at Annie M. Warner Hospital here. Erected and equipped at a cost of $225,000, the Musselman annex substantially increases facilities of this 26 year old institution. With the opening of the new building, the hospital is now thoroughly equipped in every department.

Musselman Annex, Gettysburg, Pa.

Norton Company Revises Terms of Book Contest

W. W. Norton & Company, publishers, is again offering an award for book manuscripts written for the lay public by professional workers in the field of medicine. Terms of the award have been slightly altered, according to a recent announcement; the publishers now set no final closing date for the submission of manuscripts, which may be submitted at any time, the award not being limited to any one year.

The Norton Award offers $5000 as a guaranteed advance against royalties. Either complete manuscripts or a detailed table of contents, together with 100 pages of manuscript, may be submitted.

Seek $525,000 Building Fund

A drive for a $525,000 building fund to enlarge and modernize the Highland Park Hospital, Highland Park, Ill., was undertaken last month. Before the public appeal was made, hospital officials said, a substantial portion of the necessary funds had already been donated. The contemplated expansion program includes a new maternity section, modernized surgical facilities, improvement in service facilities in the present building and a new wing which will add 50 beds. Carl Lamley is administrator of the hospital.

Seek Funds for Hospital

GREAT NECK, N. Y.—A campaign for $2,000,000 for construction of a hospital at Saddle Rock on the Great Neck peninsula, Long Island, has been undertaken. The proposed hospital was designed by Isadore Rosenfield and Edward D. Stone and will be known as the Great Neck Memorial Hospital. According to newspaper reports, it will serve a population of 70,000 persons in an area in which there is no hospital today.

Survey Recommends $30,000,000 Program for Cook County Hospital

CHICAGO.—A $30,000,000 improvement program for the Cook County Hospital was recommended last month to bring the hospital plant up to standards achieved by public institutions in other cities.

Following a detailed survey of the hospital, James A. Hamilton of Minneapolis, hospital consultant and past president of the American Hospital Association, told the county board of commissioners that Cook County Hospital is in great need of rehabilitation. "The sick and needy of this community are forced to accept a standard below that existing in New York, Boston, Cleveland and Los Angeles," Mr. Hamilton declared. "I do not mean the medical and nursing care or the management but the plant itself," he asserted. Hospital buildings are deteriorated to a point below operating efficiency and are badly overcrowded, the survey revealed.

As recommended by Mr. Hamilton, the rehabilitation program for the hospital would include repairs to present buildings, additions to kitchens and storage room, a 40 bed addition to the receiving building, a new residence for interns, additions to the general buildings to provide 1600 new beds, a new outpatient building and new units for occupational and recreational therapy.

Congress Investigates "Propaganda" Activities of Federal Employes

WASHINGTON, D. C.—A House subcommittee continued investigations June 20 of alleged lobbying activities of officials of the U. S. Public Health Service, Children's Bureau, Office of Education and other federal units. These officials, it is claimed, participated in the formation and operation of workshops in the West and Northwest, designed to implement pressure groups in favor of socialized medicine.

Dr. Mayhew Derryberry of the Public Health Service said in earlier hearings that the workshop conferences were sponsored by the National Farmers' Union, C.I.O. and A.F. of L. to discuss public health problems. The purpose was to acquaint the people with the health problems they faced and the way they could be met. At no time does a consultant tell them what decisions they should make, continued Dr. Derryberry.

Dr. Herman Hilleboe, then assistant surgeon general, U.S.P.H.S., pointed out the fact that a law provides for the service to furnish information on health matters through publications and other appropriate methods. The conferences are part of an educational program.

Two Orange Hospitals to Merge

ORANGE, N. J.—Orange Memorial Hospital and New Jersey Orthopedic Hospital will merge January 1, the boards of governors of the two institutions have announced. The hospitals will retain their names and separate identities, it was reported, but eventually it is expected that the unified hospital will be known as the Orange Hospital Center.

Under the merger plan the present orthopedic hospital unit will become a convalescent home while a $1,500,000 75 bed addition will be made to the 475 bed Orange Memorial Hospital.

The combination of the two hospitals into a single unit now will make possible economies in operation, increased efficiency and higher standards of service, the governing board's announcement said.

"It is the hope of the sponsors that other institutions eventually will become affiliated with the hospital center. The committee contemplates the gradual expansion of the facilities of the hospital center to the end that all types of medical and hospital services may be available," it was explained.

Study Program for Practical Nurse Training Makes Rapid Progress

DETROIT.—Plans for the research program in practical nurse training being conducted by Wayne University of Detroit under a grant from the W. K. Kellogg Foundation are going forward rapidly, according to an announcement from the Michigan Council on Community Nursing, one of the program's sponsoring organizations.

In cooperation with local boards of education, affiliated hospitals and other health agencies, six centers of practical nurse education will be established throughout the state of Michigan, the announcement explained. Each center will employ a coordinator, nursing arts instructor, home economics instructor and a clinical supervisor. This unit is expected to train approximately 60 students a year.

The program also includes development of testing for practical nursing competence to be used for nursing personnel not having formal preparation. Studies of the content of practical nursing training and the number of practical nurses needed to serve various kinds and numbers of patients will also be made.

Hilda M. Torrop, past president of the National Association for Practical Nurse Education, is director of the study project, whose advisers include Mildred Tuttle of the W. K. Kellogg Foundation; Adelaide A. Mayo, executive secretary, National League of Nursing Education; Ella M. Thompson, president, National Association for Practical Nurse Education, and Dana M. Cotton, director of placement, Harvard Graduate School of Education.

Arkansas Ready With Hospital-Surgical Plan

The new hospital-surgical care program developed jointly by the Arkansas Hospital Association and the Arkansas Medical Society was scheduled to be in operation by midsummer, it has been announced by Moody Moore, president of the association.

"Actual operation awaits only the opening of an office and the completion of final details," Mr. Moore said. "The coverage to be provided has been decided upon and approved and the rates to be charged have been established."

For payment of hospital bills the new Arkansas program will offer two plans: one covering the entire hospital bill with no cash limits on extras and one offering up to $3 daily for room and board and $30 for extras.

Payment to the hospitals, under the comprehensive contract, will be made at their regular established charges. The surgical portion of the program is provided through an unusually broad surgical fee schedule.

Development of the Arkansas program was undertaken by a joint committee of the hospital association and the medical society under Dr. Charles R. Henry of Little Rock, chairman. The committee made a comprehensive study of the prepayment field.

Deep Therapy Equipment Given

The first installation for deep x-ray treatment of cancer in Door County, Wisconsin, was made at the Door County Memorial Hospital, Sturgeon Bay, with the opening of a new department, including a 250,000 volt x-ray machine. All equipment for the department was donated at a cost of $11,000 by Agnes F. Ryan, Appleton, Wis., as a memorial to her late husband. The department will be under the supervision of Dr. Mary Fetter, roentgenologist, according to Franklin D. Carr, superintendent of the hospital. It is anticipated that the ready availability of effective cancer treatment will result in the prolonging of many lives in the Door County area.

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Four A.H.A. Institutes Serve 500 Wishing Refresher Courses

CHICAGO.—Approximately 500 hospital administrators and departmental executives have been attending institutes on various phases of hospital operation sponsored by the American Hospital Association and affiliated organizations during the past several months, the headquarters' office has announced.

More than 100 administrators and hospital pharmacists attended an institute on pharmacy in Chicago during the week of May 19 which was sponsored jointly by the A.H.A.'s Council on Professional Practice, the American Pharmaceutical Association, Illinois Hospital Association, Chicago Hospital Council and American College of Surgeons. Subjects covered included the application of business principles to the hospital pharmacy, purchasing and pharmacy manufacturing.

Fifty registrants studied hospital personnel relations at an institute sponsored by the University of Houston at Houston, Tex., May 26 to 30. Hospital, industrial and business personnel experts led discussions and conducted seminars on various phases of personnel management for hospitals.

The American Association of Nurse Anesthetists was co-sponsor of an institute held in New Orleans, May 26 to 30, at which 160 nurse anesthetists took part in refresher studies of the physiology of circulation and respiration as it relates to anesthesia. The program for this institute included visits to New Orleans clinics for observation of new anesthesia technics.

More than 85 persons attended the first institute on hospital public relations held June 9 to 13 in Princeton, N. J., under the sponsorship of the American Hospital Association and the New Jersey Hospital Association. All phases of hospital public relations were discussed, including the hospital's relation to its employes, patients, staff members, trustees, nurses, the press, visitors and the general public. Various types of publications used in public relations programs, the importance of various hospital procedures in establishing good public relations, and public relations in fund raising and student nurse recruitment were among topics discussed.

Rehabilitation Institute at N. Y. U. to Be First Unit of Center

NEW YORK.—The Institute of Rehabilitation planned as an important part of the New York University-Bellevue Medical Center has been given top construction priorities in the $15,000,000 medical center building program, Chancellor Harry Woodburn Chase of New York University announced last month. The institute will include accommodations for 300 patients with appropriate facilities for rehabilitation training.

There are more than 1,000,000 disabled persons in the New York metropolitan area, Dr. Howard A. Rusk, chief of the university's department of rehabilitation and physical medicine, explained in describing plans for the institute. It is expected that work done at the medical center will set a pattern to be followed in other communities, Dr. Rusk added. He said the institute would offer graduate and postgraduate training for medical students, physicians, physical therapists, occupational therapists, nurses, social workers and others needed in rehabilitation work.

Army Seeks Big Research Center

WASHINGTON, D. C.—Congressional approval is being sought for a $40,000,000 army medical research center to be located here. Plans include a 1000 bed hospital, an institute of pathology, medical museum, central laboratory group and an institute of medicine and surgery. All army medical research would be concentrated here.

Volunteers in V.A. Hospitals

WASHINGTON, D. C.—A two day meeting was held in Washington to discuss the nationwide plan of volunteer assistance in the Veterans Administration program for hospitalized veterans. The discussion was conducted by the national advisory committee of the V.A. Voluntary Service under the chairmanship of F. R. Kerr, assistant administrator for V.A.'s special services. A nationwide sampling of the contributions that volunteer citizen groups are making toward the recreation, welfare and recovery of veterans in V.A. hospitals has been released by V.A.

Wins Remington Medal

WASHINGTON, D. C.—Dr. Rufus A. Lyman, former dean of the University of Nebraska College of Pharmacy, was awarded the 1947 Remington medal by the American Pharmaceutical Association at a meeting in New York recently. The honor is conferred annually upon the person whose work is judged most important to American pharmacy by a committee consisting of past presidents of the association. Dr. Lyman has been a national leader in pharmaceutical education; he was founder of the *American Journal of Pharmaceutical Education* and is its editor.

ABOUT PEOPLE

(*Continued From Page* 84.)

of absence for six months. Assuming the responsibilities of administrator, starting in September, will be **Nelson R. Henson** who was formerly director of the Training Facilities Service of the Veterans Administration.

Dr. Claude W. Munger, director of St. Luke's Hospital, New York City, has been appointed a member of the hospital advisory committee of Associated Hospital Service of New York.

Arthur W. Smith, formerly assistant hospital administrator of Royal Victoria Hospital, Montreal, Que., has been appointed administrator of Overlook Hospital, Summit, N. J.

James W. Marine, who recently completed the course in hospital administration at Northwestern University, has been granted an administrative internship at James W. Sheldon Memorial Hospital, Albion, Mich., by the W. K. Kellogg Foundation.

Crayton E. Mann has been named administrator of Welborn Memorial Baptist Hospital, Evansville, Ind. Mr. Mann, who was formerly associated with Wesley Memorial Hospital, Chicago, and the Protestant Deaconess Hospital in Evansville, completed the academic work for his master's degree in hospital administration at Northwestern University in June.

Mary Jane Hutchinson has resigned as superintendent of the Huntington Hospital, Huntington, Long Island, N. Y.

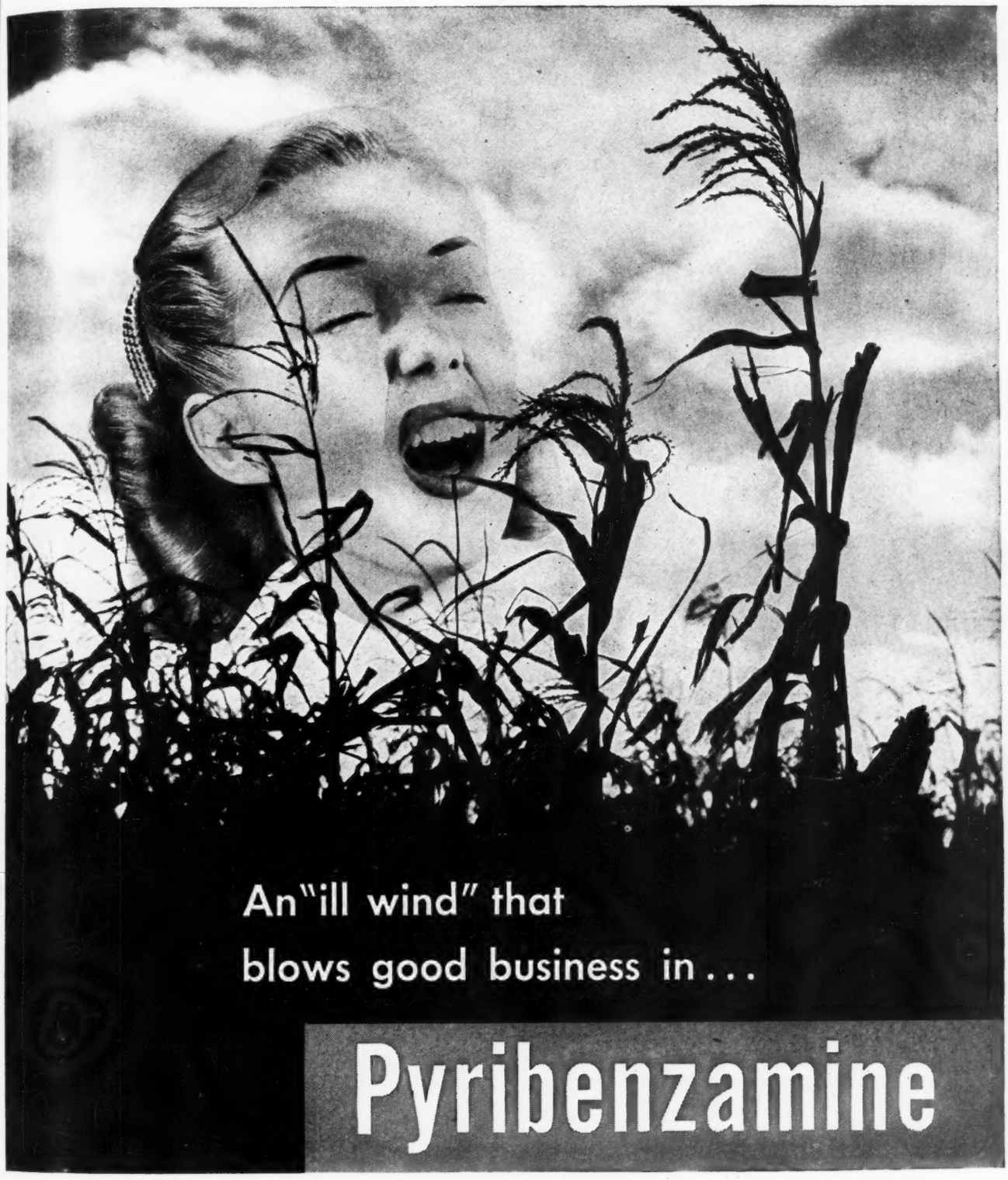
Department Heads

Mrs. Olive MacLean Northwood has been appointed director of nursing at Mountainside Hospital, Montclair, N. J. Mrs. Northwood, who served as director of nurses and principal of the school of nursing at Queen's Hospital, Honolulu, succeeds **Ruth Clements,** who recently resigned.

Dudley Keith is the new purchasing agent at Harris Memorial Methodist Hospital, Fort Worth, Tex.

J. Duncan Macdonald and **William J. Schwartz** have been appointed comptroller and purchasing agent, respectively, at Rhode Island Hospital, Providence.

John D. O'Brien has been named assistant director of the St. Louis Blue Cross plan. Mr. O'Brien has been with the St. Louis plan since it started in 1936 and occupied the position of comptroller.



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Bertha Warmbrodt, R.N., has been appointed operating room supervisor at Bradford Hospital, Bradford, Pa. Miss Warmbrodt, a graduate of Duquesne University, and National Homeopathic Hospital, Washington, D. C., was operating room supervisor at Shadyside Hospital, Pittsburgh, for twelve years.

Marion E. Gridley will return to Children's Memorial Hospital, Chicago, as director of public relations on September 2, according to announcement by **Mabel W. Binner,** hospital administrator. Miss Gridley was associated with Children's Memorial Hospital in a similar capacity in 1943 and 1944. For the last three years she has been associate director of publicity for the Chicago Y.W.C.A.

Hannah M. Mathews, R.N., has been appointed director of the nursing service and the school of nursing at Aultman Hospital, Canton, Ohio, replacing **Helen Rein.** Miss Mathews, a graduate of Aultman Hospital, received her B.S. degree in nursing at Western Reserve University. She served in the army nurse crops from 1943 to 1945.

Eleanor M. Wilson, O.T.R, has been appointed director of occupational therapy of the University of Iowa Hospitals, Iowa City. Miss Wilson is a graduate of the Philadelphia School of Occupational Therapy and of Columbia University, where she received her B.S. degree in fine arts and education. Miss Wilson has a wide background of experience in occupational therapy gained in army and veterans' hospitals. In addition, she has had specialized experience in her work with crippled children in a county public health unit in Virginia. Miss Wilson succeeds **Marjorie Iverson.**

Dr. Alfred H. Lawton has been named dean of the school of medicine of the University of North Dakota, succeeding **Dr. Harley E. French,** who is retiring to the position of dean emeritus.

Dr. Edwin J. Euphrat has been named director of the department of radiation and physical therapy at Western Pennsylvania Hospital, Pittsburgh.

Jean S. Lambie, R.N., has been selected as educational director of the school of nursing of Western Pennsylvania Hospital, Pittsburgh.

Mrs. F. G. Schafle, R.N., is the new superintendent of nurses at Andrew S. Tomb Hospital, Seminole, Tex.

Trustees

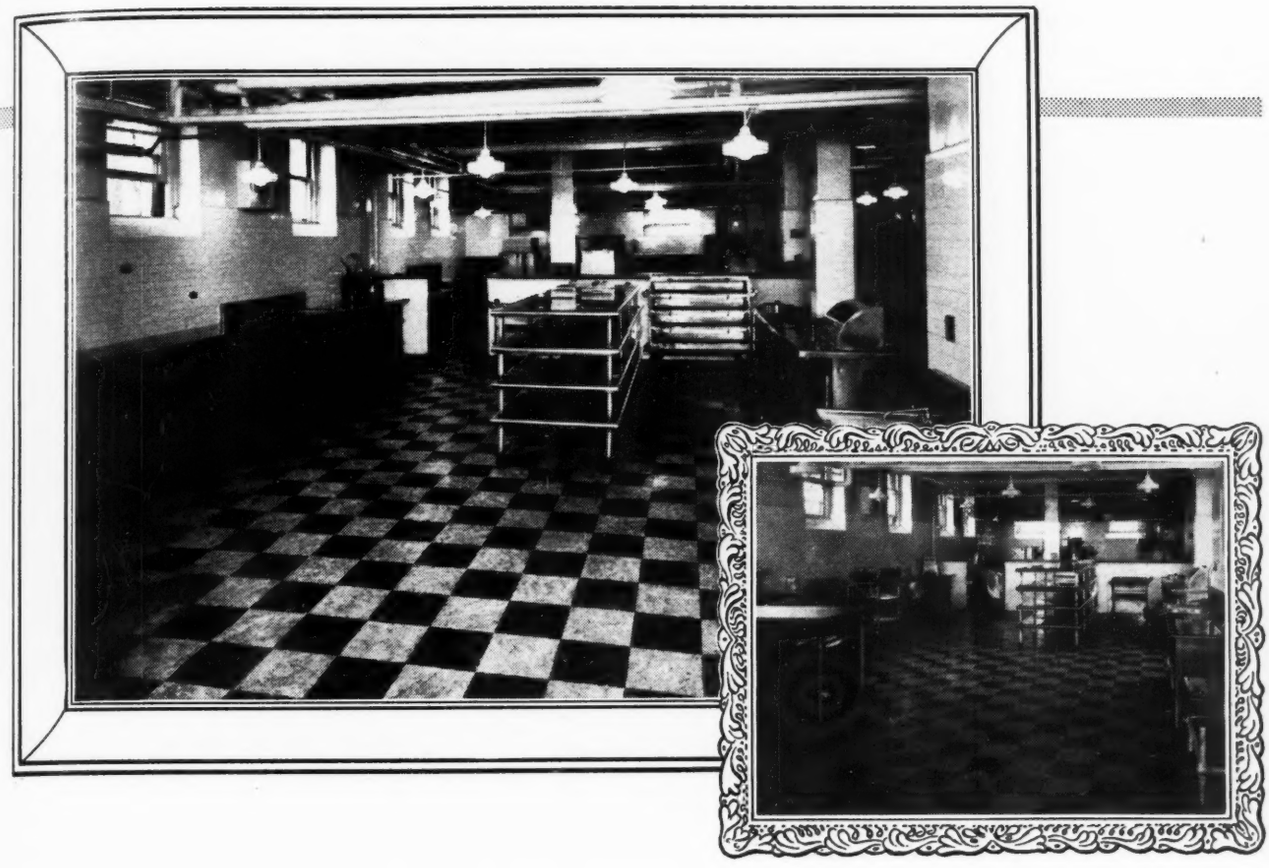
Francis B. Donovan has been elected president of Monadnock Community Hospital at Peterborough, N. H. He succeeds **Judge James C. Taft,** who recently retired because of ill health.

Miscellaneous

Ruth Coon has been appointed secretary of the health and hospital division of the Council of Social Agencies, Syracuse, N. Y. Miss Coon served as superintendent of the New Jersey Orthopedic Hospital, Orange, N. J., from 1934 to 1942. Recently she returned from a year in China with U.N.R.R.A.

Capt. J. E. Stone, consultant on hospital finance of King Edward's Hospital fund for London and author of the English textbook, "Hospital Organization and Management," will visit the U. S. in September to attend the annual meeting of the American Hospital Association in St. Louis and study U. S. hospital operations. Capt. Stone will be in the U. S. from September 16 to October 16 and will visit hospitals in New York, Chicago, Cleveland, Boston, Philadelphia and Washington.

V. Adm. Ross T. McIntire, wartime surgeon general of the navy, has been named director of the new national blood program of the American Red Cross.



Twenty years between pictures

The large photograph was taken this year in the Children's Hospital, Denver, Colorado. The other is the same hospital, same kitchen, same floor, but photographed 20 years ago, in 1927, the year the Armstrong's Linotile was installed.

Neither of these pictures has been retouched. As you study them, think of this: Thousands of feet have walked on this floor. Food, grease, and oil have been spilled on it. Kitchen equipment has been moved across its surface. But despite all this, it is still in excellent condition with a long life ahead. The only tile replaced have been in a small area where traffic was heaviest.

Case histories like this are not unusual where Linotile is installed. This floor is noted for its durable, long-wearing qualities.

Armstrong's Linotile is quiet underfoot—footsteps and rolling equipment make little noise, do not disturb patients or visitors. And it's a pleasant, comfortable floor to walk on, less fatiguing for doctors, nurses, and others who must be on their feet hours at a time.

Lower cleaning costs are another important feature of Linotile. Its smooth, lustrous surface does not catch or hold dirt or dust. It requires only routine sweeping and an occasional washing and waxing to keep it spotless and glistening.

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Deaths

Dr. David S. Moore, administrator and president of South Highlands Infirmary, Birmingham, Ala., for the last twenty-five years, died recently of coronary thrombosis. Dr. Moore was a trustee and past president of the Alabama Hospital Association; member of the Birmingham Hospital Council, and a charter member and secretary of the Hospital Service Corporation of Alabama.

Dr. Hugh K. Berkley, widely known pediatrician and former chief of staff at Children's Hospital, Los Angeles, died July 12 at the age of 57.

THE BOOKSHELF

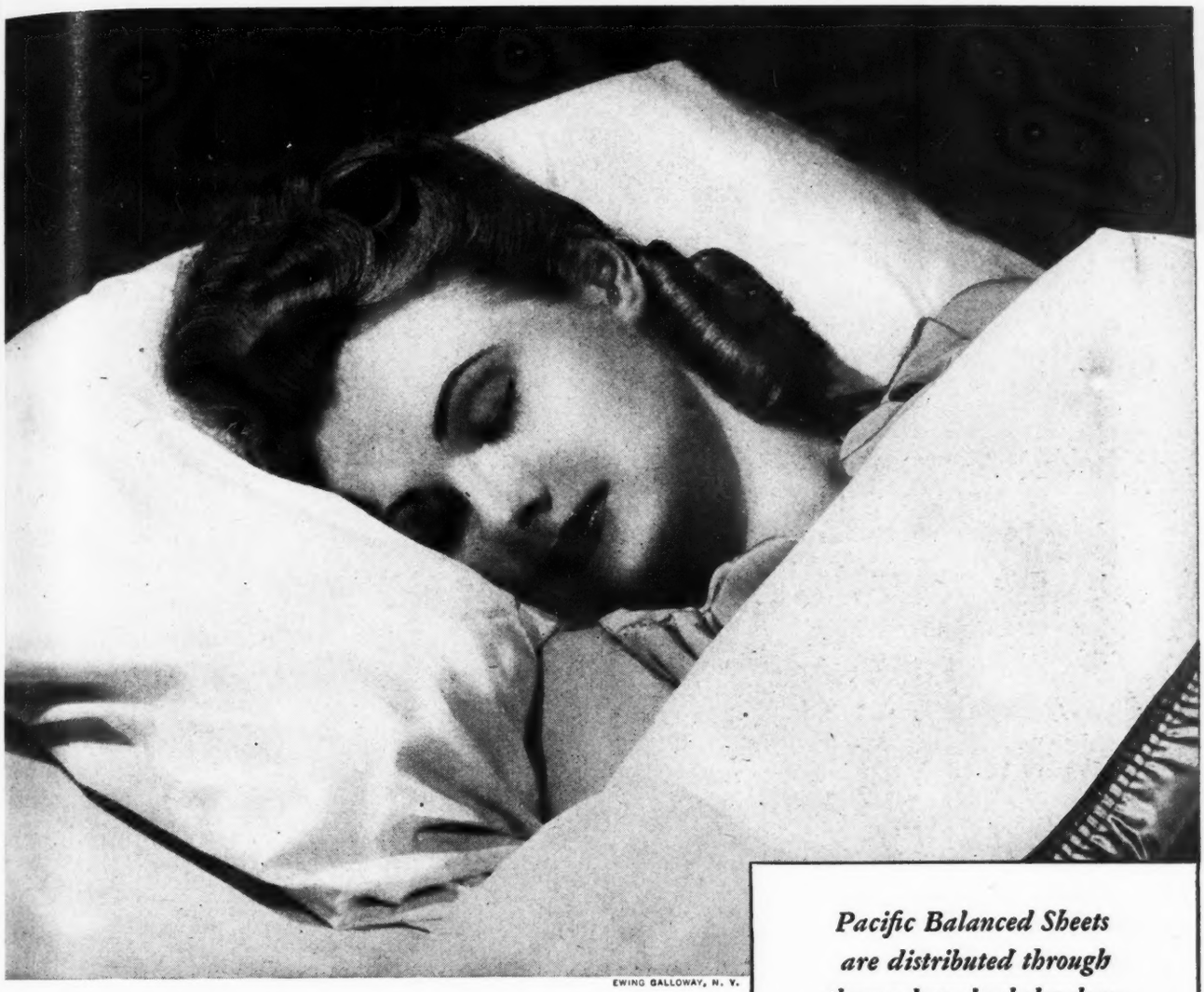
A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION. *By Morris Fishbein, M.D. Philadelphia: W. B. Saunders Company.* 1947. Cloth. Pp. 1226. $15.

If not the weightiest book of the year, this is unquestionably one of the heaviest. Its 1200-odd pages add up to something approaching seven pounds of reading matter, including, among other features, a chronological account of the association's development over its first hundred, or hardest, years; separate biographies of its 101 presidents and nine distinguished service medal winners; descriptions of its various councils, bureaus, offices and publications and How They Grew; pictures of everybody from the bewhiskered founders to the snake on the original A.M.A. caduceus, and an index listing such notable characters as Susan B. Anthony, Alexander Graham Bell, Winston Churchill, John D. Rockefeller, Mrs. Franklin D. Roosevelt and Dr. Morris Fishbein, who made a lot of the history he has written here.

As is necessarily the case in a compendium of this type, there are wide variations in interest and readability from section to section of the book—from the comparatively dull and endlessly detailed accounts of how and why and by whom certain association activities were organized and undertaken, for example, to Dr. Fishbein's lively chronicle of his twenty year battle of wits with John R. Brinkley, the goat gland virtuoso.

Scarcely a volume to be read from end to end as one might read a less specialized type of history, this is nevertheless a valuable reference work which should be in every hospital and medical school library. Here are records of all the important association actions and statements relating to hospitals, including the first dark forebodings about "exploitation of roentgenologists in hospitals" (p. 408), an early assertion that hospitals "are but expansions of the equipment of the physician" (p. 410), the origins of federal interest in medical care and hospital construction and many other subjects which are still on the discussion program of every medical and hospital group.

The reader who is interested in any one subject, such as, say, medical education or government relations, is under a certain amount of strain, since the entire work is organized more like a logbook than a conventional history, with these and other subjects popping up for a fast paragraph every half dozen pages or so, marking the grist of another year. Thus a single page (435, for example), like a train whizzing past fence posts, may deal with group hospitalization, publicity, taxation, quackery, the house of delegates, the Red Cross, air conditioning, movies, medical publications, antivivisection and rural medicine. Considering the multiplicity of problems asso-



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ciation officials have constantly to handle, the breathless reader must acknowledge that the method is realistic, if not exactly scholarly.—R. M. C. Jr.

A62 Guide for Modular Coordination. *By Myron W. Adams and Prentice Bradley. Boston: Modular Service Association.* 1946. *Cloth. Illustrated.* Pp. 290.

Anyone concerned with the design or construction of buildings knows the complications involved in the assembly of materials in currently available sizes. The comparatively simple case of a wall with face brick on one side and glazed tile on the other requires coordination between two sizes of masonry units and two thicknesses of joints, bonded together and fitted around windows, doors and other built-in units, all with unrelated dimensions.

In 1938 an industry-wide approach to a solution of this problem was initiated by the American Standards Association. The resulting conference authorized a project sponsored jointly by the American Institute of Architects and the Producers' Council with the following scope:

1. The development of a basis for the coordination of dimensions of building materials and equipment, and the correlation of building plans and details with such dimensions.

2. Recommendation of sizes and dimensions as standards suitable for dimensional correlation.

The results of the study of A.S.A. Sectional Committee A62 composed of more than 50 members representative of the construction industry and a technical staff provided by the Modular Service Association (a nonprofit corporation) have now been published in the "A62 Guide for Modular Coordination."

The work of the committee has had two objectives: (1) to determine what standardization was practicable and to develop a practical unit of coordination and (2) to organize the construction industry to produce units conforming to the established standard.

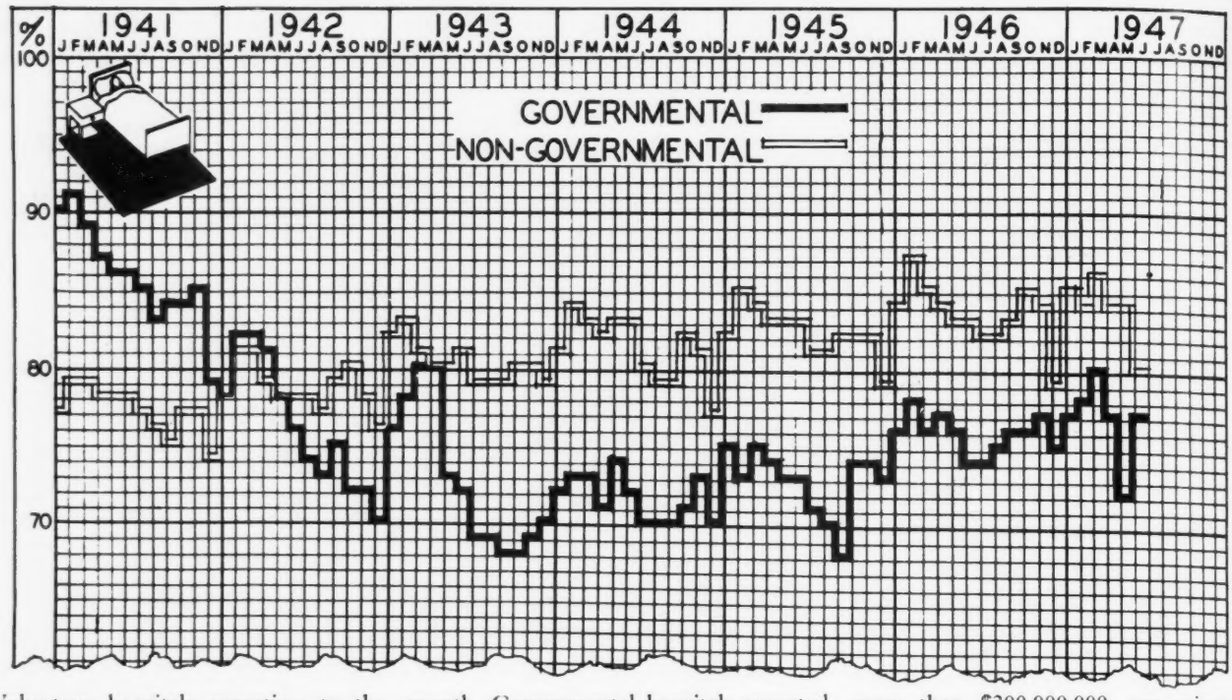
The A62 Guide describes the results of the first part of this study. It recommends a 4 inch module and proposes that designs and working drawings be based on a grid of 4 inch units within which building materials are fitted and to which all dimensions are referenced. Ideally, all units of material and equipment would be nominally 4 inches or multiples of 4 inches in width, length, height, with actual dimensions adjusted for joints and connections.

The second part of the study has resulted in progress toward the production of materials and units to conform to this module. Most masonry products—brick, structural tile, facing tile, concrete masonry and glass block—are now produced in modular sizes. Stock steel and wood windows conform and the 4 inch module itself fits the normal dimensions of wood framing, wallboards, insulation and many finished materials.

The purpose of all this study is, of course, to reduce building costs by facilitating the use of stock materials rather than specially fabricated sizes and by simplifying assembly on the job. There will be many cases where special conditions and design factors cannot be forced into a rigid modular scheme but the 4 inch module gives reasonable flexibility.

Sufficient materials are becoming available in modular sizes to permit a start toward modular design, and with further cooperation by material manufacturers it could become standard practice. The guide as published is an excellent approach toward solving the complexities of construction in such a building as a hospital where many different materials should be more simply and skillfully combined than has been possible up to the present time.—Nathaniel A. Owings.

Hospital Construction Up 33 Per Cent



Voluntary hospitals reporting to the Occupancy Chart for the month of June indicate that occupancy was at 79.6 per cent of bed capacity, the lowest occupancy reported by these hospitals since December 1945, and a drop of more than 4 per cent from the previous month. Governmental hospitals reported 76.5 per cent of beds occupied, an increase over the previous month and over the same month last year as well.

Hospital construction reported for the last period totaled $21,089,245, bringing the construction total for the year to more than $200,000,000, approximately 33 per cent higher than the total at this time last year. Of 46 specific projects reporting costs, 19 were new hospitals costing $8,453,000; 26 were additions costing $10,336,745, and one was a nurses' home at $1,220,000.